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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the Hearing held in Montreal, Province of Quebec, 16th day of April, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL

MISS ALICE GIRARD, Q.C.

DR. DAVID M. BAIRD

PROF. [illegible]

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C.J. STRACHAN

DR. ARTHUR [illegible]

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. [illegible] LAFRANCE

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Proceedings of the hearing
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COMMISSION MEMBERS:

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SECRETARY:

MR. N. LAFRANCE

THE CHAIRMAN: We will now come to order and we will proceed with our hearing. We have made a change in the order this morning, and we are going to hear from Doctor P.H.T. Thorlakson of Winnipeg. Dr. Thorlakson appears here at the invitation of the Commission to discuss the matter of a group practice. I want to say we are very much indebted to Dr. Thorlakson for having accepted our invitation to give us the benefit of his experience and his recommendations in this most important field. I welcome you here this morning, Dr. Thorlakson, and we are now ready to hear from you in whatever form you wish to open up the discussion. We have your printed document and you may follow whatever procedure you wish in discussing it.

DR. THORLAKSON: Mr. Chairman, I will have to ask for your guidance as to how I should proceed to present this information. Do you wish me to read and explain the conclusions and summaries?

THE CHAIRMAN: That is a procedure which we have found to be quite acceptable, and having had the summaries and recommendations we can then go into a more general discussion as time permits.

S U B M I S S I O N O F

DR. P. H. T. T H O R L A K S O N

APPEARANCES:

DR. P.H.T. THORLAKSON

---EXHIBIT NO. 226: Submission of Doctor P.H.T. Thorlakson.

[illegible] in the order this morning, and we are going to hear from Doctor F. J. Goodhusen of Wichita. Dr. Goodhusen appears here in the interest of the Commission to discuss the matter in a group practice. I want to say we are very much interested in Dr. Goodhusen for having arranged for hospitalization to give us the benefit of his experience and his recommendations in this most important matter. Doctor, you have the floor.

DR. GOODHUSEN: Mr. Chairman, I will ask the question of Mr. Wilson as to how I should present my information. Do you wish me to read an opinion the conclusions are summarized?

MR. WILSON: That is a procedure which we have found to be quite satisfactory, and having the summaries and recommendations we can then go into a more general discussion at some period.

[illegible]

[illegible]

Mr. [illegible]

Dr. [illegible]

Association of [illegible]

DR. THORLAKSON: Do you wish me to speak into this microphone?

THE CHAIRMAN: Just as you are now. I don't think you have to reach for it. There is simultaneous translation here this morning, Doctor.

DR. THORLAKSON: In conclusion, ladies and gentlemen, group medical practice is not a new concept. In support of that I refer you to page 4 in which there was even a suggestion of it back in 1624, of group practice. I think these quotations on page 4 are all very significant quotations in this connection. In North America the number of doctors who are entering or establishing organized groups is steadily increasing. Development of this form of medical practice is desirable. That I think is supported by the body of the brief which explains the types of group practice on the pages indicated. The practice of medicine in organized groups is a powerful force in efficiently and economically distributing medical services of a high quality.

Organized group practice provides continuing education for its members and encourages mutual assistance which develops professional competence.

Group practice provides a balance between the younger, recently trained member of the medical team and the senior, more experienced member. They both benefit equally, I would say.

The medical practitioner of the future should become more and more involved in group practice. He should have specially trained technicians to carry out some of the routine procedures which he now performs and he

Dr. [illegible]: Is you talk as to

speak into this microphone?

MR. [illegible]: Just as you are now.

I don't think you have to speak for it. There is simul-

Dr. [illegible]: In conclusion, ladies

and gentlemen, group medical practice is not a new concept.

In consideration of that I refer you to page 4 on which there

was over a percentage of it been in [illegible] or group practice,

[illegible] these medical [illegible] page 4 are all very significant

[illegible] in this connection. In terms [illegible] the number

of doctors who are working or establishment organized

[illegible] in medicine [illegible]. Development of this form

of medical practice is [illegible]. What I think is [illegible]

by the body of the [illegible] explanation the types of group

practice on the page that [illegible]. The practice of medicine

by organized groups is a powerful force in effectiveness and

economical [illegible] medical services of a high

[illegible]

Organized group practice provides con-

siderably enhanced [illegible] for the [illegible] and [illegible] medical

[illegible] and [illegible] professional [illegible].

Group practice provides a [illegible]

between the [illegible], [illegible] limited number of the [illegible]

[illegible] and the [illegible] more experienced [illegible]. They [illegible]

[illegible] [illegible], I would say.

The medical practitioner of the future

[illegible] more and more involved in group practice. As

people have [illegible] [illegible] complaints to carry out the

[illegible] of the [illegible] procedures which he has [illegible] are be

should have medical secretaries to assist him in keeping histories and records.

Now, Mr. Chairman, the recommendations. The first one, but not necessarily in the order of importance, a "National Advisory Board on Group Medical Practice" should be created under the sponsorship of a privately endowed foundation to promote, co-ordinate and offer counselling service on the principles, policies, aid operations of group practice. That is dealt with on pages 15 and 16. I would like to bring to your attention the functions of this National Board. At this moment I am not going into the question of why this National Board should not be under the Canadian Medical Association or under a Provincial department of health or Dominion department of health. That is something that can be considered probably at some future date, but the function of this National Advisory Board would be one to advise on the organization, partnership, agreement, building, X-ray, laboratory and other equipment, hospital bed requirements and personnel and two, to arrange through the normal financial channels for necessary mortgages and other credits essential for the development of the group facilities to provide adequate medical services in the community. Three, to promote, coordinate and provide wide counselling for group medical practice. The reason I suggest, Mr. Chairman, that we have an Advisory Board on group practice is that doctors are constantly inquiring about the best way of creating a medical partnership, and I think there is enough information available now if it could be brought to one place and made available to people

that are interested in establishing a partnership or groups or clinic practice, that this should be made available to them in one place rather than make it necessary to travel hither and thither to try and sit in and have some conversation about group practice without a follow-through or local examination of the situation.

Mr. Chairman, would you like me to stop here? Is it your wish that I should answer questions on this recommendation before we go on to the others?

THE CHAIRMAN: No, I think if you proceed and then we will have the questions dealt with generally.

DR. THORLAKSON: My second recommendation deals with something that I should probably explain, and probably will explain because it is not primarily concerned with group practice, but I think group practice has a contribution to make to medical education. I refer you to page 5, the top of page 5, paragraph 7 in which I say: "To see group practice in its proper perspective however, we must study its relationship to medical education and research, to methods of hospital practice and administration, to government-provided facilities and to problems concerned in lessening the financial burden to the patient".

The medical faculty of the university should provide the "canopy" under which all medical education and medical research activities in the community are directed and approved; the medical faculty should not however be solely responsible for initiating or financing all educational and research activities. Private group practice

or other reasons, that this should be made available to them in the place rather than make it necessary to travel thither and thither to try and get an have some proper action about proof proofing without a thorough or local examination of the situation.

Mr. Chairman, would you like me to step here? Is it your wish that I should answer questions on this recommendation before we go on to the others?

Mr. I think if you pro-

[illegible] My answer presumption-

ably would with something that I should probably explain, and probably will explain because it is not primarily concerned with group practice, but I think group practice has a contribution to make to medical economics. I mean

[illegible]

say: To see group practice in its proper perspective however, we must range the relationship to medical economics.

[illegible]

The medical faculty of the university

[illegible] covers the "money" side of medical economics. The medical research activities in the country are concerned not so much with the medical faculty which is responsible for teaching, or training all professional and non-medical activities. Private group practice

can make a noteworthy contribution to both medical education and medical research.

The faculties of medicine in Canadian universities should establish "Graduate Schools of Medicine" integrated with the medical facilities and services of private medical groups when these conform to required teaching standards. This will broaden and improve the basis for postgraduate training.

My fourth recommendation, Mr. Chairman, deals with an idea which may help to solve some of the problems that are concerning both governments and universities with regard to making teaching facilities available. There is no doubt in my mind, and has not been for some years, that the universities and faculties of medicine in universities should stop thinking in terms of medical education, the practical training of doctors based on the degree of poverty in any community, that it should rely entirely on the people that are, for one reason or another, poverty-stricken. This is a concept which should be outdated, and we should think in terms of something different than that, for reasons which I am sure will be dealt with in other briefs you will receive or have received.

The appointment of a full time Teacher-Director of Medical Services should be considered. The Teacher-Director would not act as a private consultant; he would be primarily a teacher but also a liaison officer for the Medical Superintendent of the Hospital and the Dean of the Medical Faculty. This plan would, in effect, extend many of the advantages of group practice, presently the privilege of the "closed" teaching wards, to include all

The inability of medicine to generate universities, should establish "graduate schools of Medicine integrated with the medical institutes and centres of teaching standards. This will broaden and improve the basis for postgraduate training.

degree of poverty in any community, more it should rely entirely on the people here are, for the reason in mind, [illegible]. This is a concept which should be out-lined. [illegible] in terms of [illegible] differences than that, for reasons which I am sure will be clear [illegible] in a few months you will receive.

The appointment of a full time Research Director or Medical Services should be considered. The Director - Director would not act as a [illegible] but would be primarily a [illegible] also a liaison officer for the Medical [illegible] of the Hospital and the Ins of the Medical Faculty. This plan would, in effect, [illegible] many of the advantages of group practice, [illegible] the involvement of the "clinic" concept, to include all

wards, all patients, and all doctors in attendance at the hospital, on a voluntary basis, of course. This system would embrace many of the advantages of a university hospital or wing without its inherent problems. With the acceptance of universal prepaid hospital coverage the principle of free choice by the patient of his private physician can be recognized. The availability of teaching material, without the stigma of a public charity service, would be extended and increased.

The most urgent financial readjustment in a future comprehensive medical care plan would be to separate the X-ray and laboratory services from other hospital expenses and other costs for medical, surgical and obstetrical services. I urged this change in my report to the Manitoba Medical Service in 1954. This arrangement, if and when completed in all private and government medical care plans would serve a useful purpose. The patient would benefit from his insurance policy for X-ray and laboratory services in the hospital or out of the hospital. I cannot emphasize this sentence too strongly. One of the factors forcing people now into hospitals is that they cannot benefit from their tax supported insurance policy for X-ray and laboratory work unless they occupy a hospital bed. This, in many cases, is the height of folly and extravagance.

And now, the sixth item, I don't need to emphasize that. I think that planning for the future and government planning for the future should not centre completely around large public hospitals. The plan should be extended out into the community to involve other agencies

[illegible] on a voluntary basis, of course. This system would enhance many of the advantages of a university hospital or clinic without the inherent problems. With the [illegible] of [illegible] hospital-surgeon [illegible] physician can be recognized. The availability of the clinic material, without the stigma of a public charity service, would be extended and increased.

In a more comprehensive medical care plan would be to separate the X-ray and laboratory services from other hospital clinics and other costs for medical, surgical and obstetrical services. I urged this change in my report to the Montana Medical Service in 1944. This arrangement, [illegible] care plans would serve a useful purpose. The patient would benefit from his insurance policy for X-ray and laboratory services in the hospital or out of the hospital. I cannot emphasize this sufficiently. One of the factors [illegible] preventing people from into hospitals is that they cannot benefit from their so supported insurance policy for X-ray and laboratory work unless they occupy a hospital bed. This, in many cases, is the height of folly and extravagance.

And now, we shall then, I don't see [illegible] to supplanting that. I think the planning for the future [illegible] the government planning for the future even a most [illegible] [illegible] hospitals. The [illegible] [illegible] our into the community to involve other agencies

that are capable of providing the service. If we concentrate too heavily on the hospital centres we are going to over-crowd those services and probably include facilities that are available away from the hospital centres. I think I agree that we must be certain that our hospital facilities are looked after properly. We should not concentrate too heavily on that aspect of the total problem.

"Out-patient services" should, in the future, include medical, X-ray and laboratory services away from our large crowded hospitals. The payment for these services should not be limited to facilities provided by a hospital. In planning for the future the government should give serious consideration tothis point of view.

THE CHAIRMAN: Dr. Thorlakson, were there any phases in connection with your summary or recommendations that you would like to expand just at this time?

DR. THORLAKSON: I would like to refer you, Mr. Chairman, to page 5, the provision of a comprehensive medical care plan. I would like to concentrate for a moment on sentence two in paragraph 10: "Government financial assistance on a flexible scale according to need". This, I think, is the only statement in that section that provides considerable difficulty. While I am not, don't pose as an expert in this field, an answer to this has to be found. There are members of the Commission that know the answers for this better than I do, but I would like to bring to your attention one or two facts about the problem. Of course, I can only deal with the

grate too many [illegible] one big [illegible] centres we are going to overcrowd their services and probably include facilities that are available away from the hospital centre. I thi[illegible] I agree [illegible] that our hospital facili[illegible] [illegible] should not concentrate the [illegible] of the total program.

[illegible] "comprehensive" [illegible], in the future, include medical, X-ray and laboratory services away from our large centred hospitals. The payments for these services should not be limited to facilities provided by hospitals. In planning for the future the government [illegible] consideration to this point of view.

[illegible] there any points in connection with your survey or recommendations that you would like to expand upon at this time?

DR. [illegible]: I would like to refer [illegible] (Chairman), [illegible] comprehensive [illegible] plans. I would like to [illegible] reference to a paragraph [illegible] 107: "[illegible] financial [illegible] on a [illegible] basis [illegible]". This, I think, is the only [illegible] in that [illegible] since [illegible] considerable [illegible].

[illegible] the problem. Of course, I can only [illegible] the

1 situation in Manitoba. We know, Mr. Chairman, that in
2 Manitoba of a population of 950,000, approximately, we
3 have 20,000 people -- we know their names, their addresses,
4 we know their numbers -- there are 20,000 people who cannot
5 fend for themselves, that we have to provide shelter, food
6 and clothing. Now, the community, the province, the nation
7 have accepted the responsibility for these unfortunate
8 people, and the Canadian Government and the Provincial
9 Government share equally the cost of these basic needs.
10 I suggest to you that there should not be much difficulty
11 in the governments getting together to provide the fourth
12 basic need, which is medical care. I think the Dominion
13 Government and the Provincial Government should share this
14 in the same proportion as they share the three that I
15 mentioned. Then, we do know that there is an additional
16 30,000 people already categorized. That makes a total of
17 about 50,000 people in Manitoba that need assistance.
18 They have an annual income of a good deal less than
19 $2,000.00 a year and many of them are trying to look after
20 themselves and are doing so. However, they need assistance
21 when they are in difficulty and certainly they are not in
22 a position to pay premiums for health insurance to any
23 extent although they might. The ones in the upper bracket
24 of this group might pay something but here we have a prob-
25 lem of 50,000 people in Manitoba all deserving our first
26 consideration and I think we should concentrate on this
27 area of need rather than pretend or think we can solve the
28 entire problem in one fell swoop.
29 Let us take one section at a time and
30 deal with it and this is the most urgent problem and this

[illegible] in Mauritius. We have, Mr. Chairman, that in [illegible] of a population of [illegible], approximately, we [illegible]

[illegible] for diseases, that we have to provide shelter, food and clothing. Now, the community has provided, the nation has accepted the responsibility for these unfortunate people, and the Ministers Government and the Prime Minister's Government have actually the care of these basic needs. I suggest to you that there should not be much difficulty in the accommodation existing schemes to provide the needed [illegible]

[illegible] now indeed. Then, we do know that there is an additional [illegible] people [illegible] correspondence. This means a total of [illegible] people in addition to their own accommodation. They have an [illegible] of a [illegible] total [illegible] [illegible] and many of them are trying to look after themselves and are [illegible]. However, they need assistance [illegible]

[illegible] of this group may be [illegible] but I do have a good [illegible] of [illegible] people in Mauritius all [illegible]. The first [illegible] and I think we should [illegible] the [illegible] of [illegible] [illegible] [illegible] we can [illegible] the [illegible] in the "[illegible]" [illegible]

[illegible] we take one [illegible] at a time [illegible] [illegible] of [illegible] is the most [illegible] [illegible] this

we should concentrate our thoughts on those people who are at that level that may require some assistance. I would point out to you that we have an Unemployment Insurance Act which requires people to pay into unemployment insurance if they have an income of less than $5,600.00 a year or thereabouts. Certainly I think people in the lower brackets of this group will require some assistance; beyond that there is no urgency, there is no crying need in Canada to rush to their assistance. Some of them should have assistance when they run into serious difficulty and become ill and unable to look after themselves even if they previously have been self-supporting. This is not the urgent problem, and I submit to you that Government financial assistance on a flexible scale according to need is the area in which I would like to place special emphasis.

I would like to also point out that in Manitoba there are in the first 20,000 group there is a waiver of premium for their hospitalization. The Province of Manitoba, probably with assistance from the Federal Government, and I cannot see at the moment but I am sure it has happened, but there is a waiver of premium for hospital insurance, their premium is paid for out of the general tax fund, I suppose.

THE CHAIRMAN: Dr. Thorlakson, we are naturally interested in all phases of medical health and of medical services plan, but at the moment we are particularly concerned with this matter of group practice and most particularly in its relationship to rural practice. We know you are a pioneer in this field, would you care to give us the benefit of your advice and recommendations

are at that level that may require some assistance. I would point out to you that we have an Unemployment Insurance Act which requires people to pay into unemployment insurance if they have an income of less than $2,500.00 a year or thereabouts. Certainly I think people in the lower brackets of this group will require some assistance; beyond that there is no urgency, there is no crying need in Canada to run to their assistance. Some of them have had been assistance when they may take serious difficulty and become ill and unable to look after themselves even if they previously have been self-supporting. This is not the urgent problem, and I submit to you that Government therein assistance on a fifty-fifty basis according to need is the area in which I would like to place greater emphasis.

I would like to also point out that in Manitoba there are in fact fifty 50,000 people living in a matter of crisis for their rehabilitation. The Province of Manitoba, jointly with assistance from the Federal Government, and I cannot say at the moment but I am sure it has happened, but there is a matter of payment for increased immunity, which results in really one of the "seasonal" [illegible].

Mr. Chairman: Dr. Blackmore, we are

regarding the establishment of a group practice, the essentials of it and whether we might be able to find a formula which, through group practice, for a quality of care in the rural areas, the sparsely settled areas.

DR. THORLAKSON: Mr. Chairman, I appreciate you giving me the opportunity of expressing my opinions on one of the facets of the recommendation, the total health plan. As I said in my introductory remarks, group practice or private practice cannot flourish or cannot serve the public unless the climate is proper. But, coming down to this problem, the establishing of group practice in the rural area, knowing your interest in this particular aspect of the problem I did obtain two reports, areas outside of Metropolitan Winnipeg and I draw your attention first to page 20 of my report. This is an area which comprises a number of small towns and three or four municipalities and these doctors do not live in the same town, they live in three or four different towns in these three or four different municipalities. They have two hospitals, they come together as required to serve the hospital patients and then they go back home again to their respective towns to look after the needs of their immediate community. The questions that I asked this group are on the top of page 20 and they have been very largely answered.

THE CHAIRMAN: Just dealing with the Hamiota situation can it be said to have worked satisfactorily?

DR. THORLAKSON: It has worked very well indeed.

THE CHAIRMAN: Is it the kind of

[illegible]

organization of medical people which could be used, more or less, in other provinces in rural areas of other provinces throughout Canada?

DR. THORLAKSON: It is almost an ideal setup. I cannot see how a town or a group of municipalities can be provided with medical services unless the doctors in these areas get together and form some sort of arrangement of this kind to cover the area in times of absence or illness and to give the doctors, I think I have emphasized, some relief. In many areas of many cities the doctor is on duty 24 hours a day and seven days a week and in 1962 this is not a practical proposition. This, with some modification in the rural areas could well become a prototype of group practice in rural areas where there is only one doctor in a small town where there is more than one doctor in some small towns and one doctor in neighbouring towns but they could work together as a group. This has been very nicely explained and stated in Dr. Hudson's report where he says:

> "The interchange of ideas and freedom to discuss problems is the greatest advantage of group practice. I feel lost when there is no one to discuss a problem and it is amazing how many times ideas come up that I would not think of myself."

This, I think, is a very interesting observation in this connection.

THE CHAIRMAN: And is it a fact that such group practice must be hospital based, that there must be adequate hospital services in the areas as a

[illegible]

[illegible]

DR. BUCHANAN: It is about an hour's [illegible]. I wonder are you a member of a group of municipalities can be provided with medical services unless the necessary [illegible] ment of this kind to cover the area in times of absence or illness you to have the doctors. I think I have complained, I am [illegible]. In many areas of many cities the doctor is on duty 24 hours a day and seven days a week and in 1962 this is not a practical proposition. Then, with some modification in the rural areas could well become a prepaid-type of group practice in rural areas where there is only one doctor in a small town where there is more than one doctor in some small towns and one doctor in neighbouring towns but they could work together as a group. This has been very nicely explained and stressed in Dr. Buchanan's report where he says:

"The interchange of ideas and freedom [illegible] the disease problems is the greatest advantage of group practice. I feel that when there is no [illegible] one to discuss a problem and it is [illegible] you [illegible] many times come up that I would not think of myself."

Now, I think it is a very interesting [illegible] discussion in this connection.

MR. [illegible]: Is it a fact that [illegible] prepaid group practice must be hospital based, that there must be adequate medical services in the area as a

condition of a group functioning properly?

DR. THORLAKSON: I think you have brought up a very important point. One of the problems that I think every Government faces in Canada is that every young community, town or hamlet wants hospital facilities and it is not practical, because while you can provide a small cottage hospital of perhaps six to twelve beds for certain situations, it is not a hospital, it is just a nursing home with occasional medical attention. You cannot set up X-rays or laboratories of any size in such a set up. It is necessary to have hospital facilities in these places, perhaps not metropolitan area facilities because it is not practical to have such kind of hospital services in a small town or rural area that you have in the metropolitan area. In a final analysis you have to look upon the practice in the nature of wheel with the periphery and the spokes to the wheel and the hub. The hub of the wheel is the centre where medical education and medical research occurs and where the complicated problems of surgery can be attended to. This is the hub of the centre. In some areas there may be two hubs or two centres in large populated parts but the principle of having a medical teaching research centre is vital to the progress of medicine in many areas that I have mentioned. This does not exclude the desirability of having a properly equipped smaller hospital at strategic areas in the province which then serve that area but to have every little hamlet and town rush in and want to build a hospital is not sound planning.

THE CHAIRMAN: The development and

Dr. [illegible]: I think you have brought up a very important point. One of the problems that I think [illegible] needs to develop is that [illegible] and it is not [illegible], because while you can provide a small out-patient psychiatric or psychiatric care for certain conditions, in the [illegible] hospital, it is just a question of [illegible] cultural medical education. You cannot set up clinics or laboratories of any size in such a set up. It is necessary to have hospital facilities in these places, perhaps not a [illegible] area facilities because it is not practical to have such kind of hospital service in a rural town or rural area that you have in the metropolitan area. In a rural community you have to look upon the problem in the terms of where with the population and the spaces to the school and [illegible]. The hub of the [illegible] in the centers where medical education and medical research occurs and where the complicated problems of surgery can be carried on. This is the hub of the center. In some large spaces may be two hubs or two centers in large population and [illegible] of having a medical teaching [illegible] is [illegible] to the program [illegible] in every case that I have mentioned. [illegible] not [illegible] the [illegible] of having a [illegible] medical teaching [illegible] or [illegible] in the [illegible]. [illegible] when [illegible] to have [illegible] a [illegible] is not [illegible] practicing.

Dr. [illegible]: I do [illegible]

operation of a group practice in the metropolitan area, does it work satisfactorily in the larger areas as well as in the rural areas?

DR. THORLAKSON: Well, Winnipeg is a good example. We have had very good, substantial development of group practice in Winnipeg.

THE CHAIRMAN: We have been told it has probably developed more in Winnipeg than any other city in Canada.

DR. THORLAKSON: That is true. I have figures on this point but the number of practitioners in groups in Winnipeg is, and also in rural Manitoba, quite remarkable.

THE CHAIRMAN: One may readily see the advantages of the group in rural practice, but when you have the metropolitan centre and the teaching facilities and so forth available, what is the advantage of the group practice in the metropolitan area?

DR. THORLAKSON: I mentioned a moment ago that it is most important to concentrate the services, the ancillary services in the large hospitals. In the Province of Manitoba there are about 450,000 people living in Winnipeg and 450,000 people living in the rest of the province. Now, it is not practical to concentrate the medical services in the metropolitan hospitals. There again you have to think in terms of the wheel of the centres and the doctors who are practising in that community and serve that area have to have facilities. Away from the hospital, X-ray and laboratory facilities, patients should not always be sent to hospital for these

[illegible] mainly in the larger areas as well as in the rural areas.

DR. MACLAUGHLIN: Well, Winnipeg is a good example. We have had very good, substantial development of group practice in Winnipeg.

THE CHAIRMAN: We have been told it has probably developed more in Winnipeg than any other city in [illegible]

[illegible] that is true. I have figures on this point but the number of physicians in [illegible] is and also in rural Manitoba, [illegible]

THE CHAIRMAN: You may readily see the advantages of the group in rural practice, but when you have no hospital for course and the laboratory facilities and so forth not available, what is the advantage of the group practice in the hospitalization area?

DR. DR MACLAUGHLIN: I mentioned a moment ago credit is most important to concentrate the services, the ancillary services in the large hospitals. In the Province of Manitoba there is about 450,000 people living in Winnipeg and 450,000 people living in the rest of the province. Now, it is not practical to concentrate the medical services in the hospitals. There is going to need to write in terms of the wheel of the [illegible] the doctors are providing in their community and some that are here to have [illegible] X-ray and laboratory facilities [illegible] should not always be sure to be [illegible] for those

special tests, otherwise the hospitals would cease to be hospitals. We always have an out-patient department attached to a hospital but that is not the primary function of a hospital. The primary function of the hospital is to look after bed patients and not the ambulatory people. Ordinarily the out-patients work well, it can be carried out to a slight extent in the hospital.

A patient that seeks medical advice in his metropolitan area a mile or four from a hospital centre should expect the same quality and type of work that is provided by hospital facilities which means in 1962 X-ray and substantial laboratory services and medical consultation, availability for a second information. As Dr. Hudson says - that is one of the things here I would like to speak about, this being able to speak to someone very easily and these men who have established group practices or clinic practices in any area have that, they have everything under one roof, these many facilities are available not only to the patient but to the doctor.

I might go back to this question. In Metropolitan Winnipeg there are 216 doctors practising in groups and in rural Manitoba there are 46 doctors practising in groups. In Manitoba there are approximately 1100 doctors, but 100 of these are retired or inactive, about 75 are in Government or university services which brings the total down to about 950 doctors presently in Manitoba in private practice. Now, 216 and 46, that is almost 270, about 25% of the doctors in Manitoba are now in group practice or partnership practice.

special tools, medicine the needle's would cause us be hospitalize. We always have an independent department attached to a hospital but that is not the ordinary function of a hospital. The ordinary function of the hospital is to look a for bad patient and for the ambulatory people. Ordinarily the out-patient work will, it can be carried out to a slight extent in the hospital.

A patient that really needed advice.

In his metropolitan area a lady or gentleman.

Hospital centre should accept the same quality and type of work that is provided by hospital facilities which cause to have X-ray and chemical laboratory services and medical consultation, availability for a second information. An Ian Macmillan says that because of the things there should like to speak about, this being able to report to science very quickly and clear men who have established group practices or single practices in any area have that they have everything under one roof, those many facilities are available not only to the patient but to the centre.

Tudgay is next to this question. I.

Mercedes Hospital are 210 centre providing in Europe and in some, there is the chance to concern practice in groups. In Scotland there are approximately 120 centres, but we do have two centres of three, about [illegible] doctors. [illegible] advance which is [illegible] the point of view [illegible] centres practically in Mercedes in private practice. [illegible] and [illegible], need to [illegible] 10, which any of the centres in Scotland are [illegible] people [illegible] [illegible].

COMMISSIONER BALTZAN: Dr. Thorlakson, I welcome you personally and I welcome your remarks, because they are borne out of your personal experience along with your group practice, or clinic.

May I at the first turn to page 2, and your recommendation number 1 which reads: "A National Advisory Board on Group Medical Practice ---" is one of the constructive propositions that you make, and you have stated some of your reasons, and I shall not question you, but I would like if possible if you could submit later on greater detail on the manner in which this National Advisory Board which you advocate would function. Do you think you might in the next month or two supply us with greater detail, such as I understand you have, and you were not able to incorporate in your presentation?

DR. THORLAKSON: I would be glad to try to do that. I wish now that I had kept a record of the number of doctors who have come to see me in the last ten years for information about group practice, not only from Winnipeg and Manitoba, but from other parts of Canada, and I look back on this experience and feel how inadequate this advice has been, and the lack of follow-through, the lack of study on the spot. I have an idea they would like to do something different, something better, and I talked to them and gave them the benefit of my opinions, and as I look back on it I think that is very inadequate, and there should be something more concrete and practical, based on the clear understanding of the needs of the area which they hope to serve.

COMMISSIONER BALTZAN: We shall be glad

to receive that in due course. Number 2 of your recommendations: "The Medical Faculty of the university should provide the 'canopy' under which all medical education and medical research ---". Is this based on the principle that there is no monopoly on ideas?

DR. THORLAKSON: Yes, I think that expresses it very well.

COMMISSIONER BALTZAN: Number 3: "The faculties of medicine in Canadian universities should establish 'graduate schools of medicine' --" and you referred previously to the canopy of their role at the university. My question to you sir, in this connection you refer to schools under one roof that provide post-graduate courses in medicine, or graduate programs in recognized and accredited areas, the departments of hospitals, and also clinic groups that you advocate.

DR. THORLAKSON: At the moment I am not thinking of separate buildings, separate schools, or separate faculties. Our universities and medical faculties are organized to train, to accept students who will graduate after three or four years in the university and five years in the medical school with one year internship. They are then equipped to go out into what we now call, or have called, general practice. Now we require, and it is recognized that that is only the beginning of medical education, and certainly not the end of it. Even if a man goes out to practice, he has got to continue his education and come back to the centre for further instruction.

Now, this is a postgraduate or graduate

facility, and I do not mean that we should have a separate faculty at the moment, or a separate organization, or facilities. It should be part of a total medical faculty planning. At the moment postgraduate training is based on the needs of each department of medicine and the hospital department, and then to meet the requirements of the Royal Colleges of Physicians and Surgeons that have set up certain standards, and these standards are excellent, and it prepares the young man to write his examinations for these advanced examinations which have done so much for the progress of Canadian medicine, but these are not university programs. They are largely controlled by the teaching hospitals, which have been accredited, and therefore I suggest that there be, for want of a better term, graduate schools of medicine and programs of graduate education under the direction of the university and controlled as a university project, rather than geared to the needs of the hospital and the facilities in that hospital for senior residents and the training of residents.

COMMISSIONER BALTZAN: I am going to just try to strike at a few highlights here, because time is very limited. On the same page, in Paragraph 5 you stress the separation of X-ray and other laboratory services from other hospital expenses and other costs for medical, surgical and obstetrical services. Would you explain your special emphasis on that point?

DR. THORLAKSON: I think one of the greatest requirements is not legislation at the moment, but education in this field of medical care. People subscribe, or pay in insurance prepaid medical and

[illegible] ability, and I do not mean that we should have a [illegible] [illegible]. At the moment postgraduate training is based on the needs of each department of medicine and the [illegible] department, and tries to meet the requirements of the Royal College of Physicians and Surgeons that have set up certain standards, and [illegible] are [illegible], and

[illegible] programme of Canadian medicine, but these are not universally [illegible]. They are largely controlled by the teaching [illegible], which have not necessitated, and therefore I [illegible] that there be, the need of a better term, [illegible] [illegible] of medicine and [illegible] of graduate education under the direction of the university and connection as a university [illegible], rather than geared to the needs of the hospital and the facilities in that hospital for service research and the training of residents.

[illegible] PARKER: I am going to [illegible] to [illegible] at a few highlights here, because this is very important. On the same page, in paragraph 1 [illegible] the association of X-ray and other laboratory service from other hospitals, and organize one other course for [illegible], [illegible] and [illegible]. Would you explain your [illegible] [illegible] on that?

[illegible] I think one of the [illegible] is not legislation at the moment, [illegible] the [illegible] of medical care. Public [illegible] or [illegible] in hospitals [illegible] and

hospital insurance, and this principle has been generally accepted, and it is difficult for many people to realize what they are paying for when they buy insurance, and a substantial number of citizens believe that when they have paid a number of years into a scheme of this kind that they have built up a reserve which they could draw upon. They do not realize that at the 31st of December every year this is all written off because the money they haven't used has helped somebody else who has been sick. This has been one of our greatest problems, the person who says: "I have been paying in for five years, it is about time I should get something out of it", and we say you are fortunate, you haven't had a fire in your house, so you didn't get fire insurance. You haven't been sick, so you didn't get sickness insurance. They say I have been paying my tax and my premiums and it says there I am entitled to X-ray, electrocardiograph, and to get them I want to into hospital. If I am not in hospital I have to pay the hotel bill if from outside the city. So people go into the hospital and become bed patients for investigation, and I am sure all of you realize it is the first three or four or five days in the hospital which is most expensive, because it is during that period that intensive investigation is occurring, and for men and women to go and live in the hospital while they are conveniently provided with these facilities and use the hospital as a hostel or hotel is the height of folly and extravagance.

We say to the patient you have a prepaid insurance plan which provides you with X-rays and laboratory services, and you can have these either outside

or inside the hospital. We are selling people policies, and every policy included some of these extra facilities, so they were being sold two or three times over.

COMMISSIONER BALTZAN: Just very briefly, if you can give it to me, the finish-up of your last remarks. Out of the cost dollar to the patient, what amount, or what percentage is covered by the X-ray and laboratory, versus the medical services?

DR. THORLAKSON: Unfortunately I cannot give you exact figures on this, but my information is that this comes to something in the neighbourhood of 35%, and then in private practice one has to think in terms of overhead, so that if a doctor charges $5.00 for his care, he does not get $5.00. In 1962 he has to pay substantial rent and overhead and facilities that patients require and should have, and roughly the cost of providing these services is two and a half to three dollars out of the $5.00 charge, and if the charge goes up to ten or fifteen dollars it does not mean the difference between three and fifteen dollars, because if you provide a $15.00-service you are using more time and provide the patient with greater facilities, so that one should not think in terms of a fee going to the doctor. A very substantial amount of that fee goes to pay for overhead and the cost of ancillary services.

COMMISSIONER BALTZAN: On page 5 you and the group practice people advocate that we support comprehensive medical care. Number 3 in A, under 10. I would like just simply to repeat number 5: "Acceptance and participation in administration but not complete control by

the medical profession". That is in any prepaid comprehensive plan, you submit that the medical profession has not complete control?

DR. THORLAKSON: I am sure this is correct, Mr. Chairman, and I am sure the community would accept this in principle, and I am sure the community should accept the fact that any plan should be acceptable to the group that are providing the services, and they should have some participation in the administration of those services, but not complete control, because doctors by themselves I don't think are necessarily trained to look after all the needs of these services, and they need help and advice just as much as anybody else does in the community, and certainly community participation is very vital to the success of this type of undertaking. There should be no monopoly, there should be no domination by any segment of society. What I would like to see, and I am sure what everybody would like to see, is a healthy cooperation, and this includes Governments, the medical profession, nurses and other services, and also includes the private insurance companies, who have facilities that can be used to the benefit of this national and provincial development.

COMMISSIONER BALTZAN: On page 12, the group people in group practice, at the top of the page you say, number 10: "The elimination of the direct monetary relationship between doctor and patient, and the availability of competent business management to assist in these relationships." Now, that has proved a serious issue with us in presentations received from various medical

the medical [illegible] section". That is in any prepaid comprehensive plan, you found that the medical profession has no [illegible]

. MCGRAKDER: I am sure that is correct, Mr. Chairman, and I am sure the community would [illegible] pay while in practice, and I am sure the community should accept the idea that any plan should be acceptable to the group that is providing the services, and they should have some participation in the administration of those services, but not complete control, because doctors by themselves I don't think are necessarily trained to look after all the needs of these services, and they need help and advice just as much as anybody else does in the community, and certainly community participation is very vital to the success of this type of undertaking. There should be no secrecy, there should be no deep feeling by any segment of society. What I would like to see, and I am sure what everybody would like to see, is a healthy cooperation, and this includes Governments, the medical profession, nurses and other services, and also includes the private insurance companies, who have facilities that be used as the basis of some national and provincial development.

CHAIRMAN: On page 12, the group people in group practice, at the top of the page you say, number [illegible] of [illegible] of [illegible] of correctness insofar as [illegible] in these institutions." How that has proved a [illegible] when we in practice have received from various medical

organizations, and you are a form of medical organization, you come under the "canopy".

DR. THORLAKSON: I am sure, Mr. Chairman and Dr. Baltzan, that most doctors would like to be relieved of any responsibility of this nature. We are not trained in this field, and most of us just do not feel very happy about being involved in the transaction where our services are being paid for, but unfortunately this is necessary because doctors have to pay their overhead and their staff and the living costs just like anyone else, and I think that the doctor who has spent, seven, six to twelve years in training for a specific job, of looking after sick people and diagnosing diseases and treating diseases, and restoring people to their health, this is something which should require the major part of his time, and he should be relieved as much as possible by his staff, his medical secretaries, and the technical assistants, of anything dealing with these other matters. He must however, be informed about these matters, but not use his time in dealing with them.

COMMISSIONER BALTZAN: We have been confronted by inconsistencies in some submissions in respect to this question that we have just been discussing relative to the payment, as to who makes the payment, and we have noted that the medical profession very definitely endorses receiving payment from voluntary organizations, and we have noted also an opposition to payment through a Government plan, and one would take both of these plans as third parties. This is an inconsistency, and there must be some profound reasons. While it is an

organizations, and you are a form of medical organization, you come under the "company".

DR. THORNBURGH: I am sure, Mr. Chairman and Mr. Larson, that our doctors would like to be relieved of any responsibility of this nature. We are not trained in this field, and most of us just do not feel very happy about being involved in the transaction when our services are being paid for, but unfortunately this is necessary because doctors have to pay their overhead and their staff and the living costs just like anyone else, and I think that the doctor who has spent, seven, six to twelve years in training for a specific job, or looking after sick people and diagnosing diseases and treating diseases, and restoring people to their health, this is something which should require the major part of his time, and he should be relieved as much as possible by his staff, his medical secretaries, and the technical assistants, of anything dealing with these other matters. He must however be informed about these matters, but not use his time in dealing with them.

COMMISSIONER BATTAM: We have been confronted by interlocutors in some submissions in respect to this question that we have just been discussing relative to the payment, or to who makes the payment, and we have noted that the medical profession very definitely endorsed receiving payment from voluntary organizations, and we have noted also an opposition to payment through a government plan, and one would take both of these plans as quite positive. This is an inconsistency, and there must be some profound reasons. While it is an

inconsistency, it is not necessarily a contradiction.

Do you endorse the principle and practice of prepayment by voluntary medical plans. I think you answered that in your brief?

DR. THORLAKSON: Yes.

COMMISSIONER BALTZAN: Well, we will bypass that point then. Do you and your type of practice by group methods, do you oppose deriving payment from Government sources only covering the medical services?

DR. THORLAKSON: Yes, Mr. Chairman and Dr.Baltzan and gentlemen, I think this is crucial in the whole arrangement, and I can answer that most quickly by repeating what I have said. Government aid should aim to avoid hardship and relieve unnecessary suffering; it should not go beyond this and discourage thrift, self-reliance, independence and free choice. The supervision and management of a comprehensive medical care plan must be independent of political influence and control but not necessarily too remote from political criticism.

I challenge anyone who says that there will be no difference for the patient or the doctor if and when a completely government sponsored and government controlled scheme of collecting premiums, supplemented from the general tax fund is instituted and the bills for medical and surgical services are sent to a government agency.

In our society all citizens should have direct access to the law courts to settle any grievance that may properly be referred to a judge and his court for decision. The record in Canada has been clearly established

incompatibility, it is not necessarily a contradiction.

Do you endorse the principle and practice of prepayment by voluntary medical plans, I think you answered that in your brief?

COMMISSIONER LAIRVANE: Well, we will bypass that point then. To you and your type of practice by group medicine, do you oppose deriving payment from government sources only covering the medical services?

Dr. Sawyer and gentlemen, I think this is crucial in the whole arrangement, and I can answer that most quickly by repeating what I have said. Government aid should aim to avoid hardship and relieve unnecessary suffering; it should not go beyond this and discourage thrift, self-reliance, independence and free choice. The supervision and management of a comprehensive medical care plan must be independent of political influence and control but not necessarily too remote from political authority.

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In our society all citizens should have direct access to the law courts to settle any grievance that may properly be referred to a judge and jury for decision. The system in Canada has been nearly established.

that a government agency soon begins to function not only as an arm of government but also as a court of law. Its decisions are final. The agency cannot be sued. It becomes another great government monopoly, arbitrary and largely unapproachable by the average citizen who supports it through his taxes.

I don't mean by this that there are not certain areas where the Government should get into the business of running things, but it should try its best to stay out of doing things where private citizens and private institutions can do, I think and I believe most legislatures believe, that they can do better than most Government agencies, and probably more economically in the long run.

COMMISSIONER FIRESTONE: If I may just carry on where Dr. Baltzan, with one of the questions Dr. Baltzan raised, and I am referring to Paragraph 34, sub-paragraph 10, in which you speak of the advantages of group practice from the doctors' point of view, and you mention in this paragraph: "The elimination of the direct monetary relationship between doctor and patient, and the availability of competent business management to assist in these relationships."

Do you feel that this is also helpful to patients, and do patients approve of this arrangement?

DR. THORLAKSON: Yes, I think that is correct.

COMMISSIONER FIRESTONE: The next question is have you found that this elimination of direct monetary relationship between doctor and patient has affected the quality of medical services?

as an aim of government our also as a court of law. The decisions are final. The money cannot be used. It becomes another great government monopoly, arbitrary and largely unappreciable by the average citizen who supports it through his taxes.

I don't mean by this that there are not certain areas where the government should get into the business of marketing energy, but it should be the best way out of doing those things private citizens and private institutions can do. I think and I believe most legislators believe, that they can do better than most governments operates, and probably more economically in the long run.

COMMISSIONER FINNEGAN: If I may, just carry on where Mr. Mitchell, who, one of the questions Dr. Balcom raised, and I am referring to Paragraph 34, sub-paragraph 10, in which you speak of the advantages of group practice from the economic point of view, and you mention in this paragraph. "The elimination of the direct monetary relationship between doctor and patient, and the availability of competent specialist assistance to assist in these related ships."

Do you feel that that is also material to patients, and do patients approve of this arrangement?

DR. THORNBURN: Yes, I think that is

Commissioner Finnegan: Another question is have you found our this administration of annual monetary to accomplish however doctor and patients from at the quality of medical services

DR. THORLAKSON: I can't say that I have noticed it. I can't measure that. It is my impression this tends to improve the quality of medical practice.

COMMISSIONER FIRESTONE: In fact, you said a little earlier, sir, in giving us an example of group practice in rural areas that the opportunities that doctors have to discuss cases among themselves improves the quality of medical care, that least, that is the implication I gathered from the statement. Therefore, there is no evidence that you have, sir, in the experience you have had or in Manitoba group practice of other people that the quality of medical services suffered as a result of group practice, on the contrary, I think you are telling us it has improved.

DR. THORLAKSON: If it hasn't improved, if the members of the group get together and practice group practice as I understand it, if the quality of practice does not improve there is something radically wrong with the organization, with the set-up or the reason for setting up the organization.

COMMISSIONER FIRESTONE: You have no evidence that the quality of medical service has deteriorated as a result of group practice?

DR. THORLAKSON: None whatsoever.

COMMISSIONER FIRESTONE: Thank you very much, sir. Would you further say, Doctor, that as a result of group practice and the implementation of medical secretaries helping in the establishment and keeping of case records this would increase the efficiency of the doctor?

DR. THORLAKSON: Very definitely,

DR. THOMPSON: I can't say that I have noticed it. I can't measure that. It is my impression this trade to improve the quality of medical service.

COMMISSIONER FINSTROM: In fact, you said a little earlier, sir, in giving us an example of group practice in rural areas that the opportunities that doctors have to die-hard cases among themselves improve the quality of medical care, that least, that is the implication I gathered from the statement. Therefore, there is no evidence that you have, sir, in the six years you have had or in Kentucky group practice of other people that the quality of medical services suffered as a result of group practice; on the contrary, I think you are telling us it has improved.

DR. HOWARD: It it doesn't improve, it has measures of the results get together and provide group practice as I understand it, if the quality of medicine does not improve there is something really wrong with the organization, with the set-up or the reason for getting to the organization.

COMMISSIONER FINSTROM: You have no evidence that the quality of medicine practiced as a result of group practice?

DR. THOMAS ARNOLD: None whatever.

COMMISSIONER FINSTROM: Thank you very much, sir. Mario von Tornow, Doctor, and as a result of group practice and the improvement of medical service, [illegible] in the health insurance [illegible] the [illegible] the quality of the doctor?

because I think medical secretaries and medical technologists can do a great deal to facilitate the care of the patient and keep records. We now realize more than ever the patient's record must be available. We place great emphasis on proper history taking and proper examination and proper recording, and this is one of the great weaknesses in the past in sole practice. The doctor wasn't able to obtain it or have this type of facility, but in a properly organized group this is one of the things that we emphasize, the availability of records and the maintaining of records to be referred to because so often a patient will come in today and he has a problem and if you can relate it to some complaint or disability or test on the record a year ago, a month ago, or five years ago, it is great help in the diagnosis and prognosis of the case.

COMMISSIONER FIRESTONE: Would you therefore say, Doctor, as a result of the increase of doctors in group practice that they would be able to see more patients and give them better quality of service?

DR. THORLAKSON: I think this is correct, Dr. Firestone.

COMMISSIONER FIRESTONE: As a result, therefore, if we had more group practice in Canada the same number of physicians could provide substantially greater service to the Canadian people and of a higher quality?

DR. THORLAKSON: Well, Mr. Chairman, Dr. Firestone, as I pointed out in my brief we can look forward to difficulty in obtaining an adequate number of doctors to serve this community. There is no question in

my mind this is something we will have to face. It is one of the most serious problems facing Canadian medicine and the Canadian nation at the present time. I said in my brief 25% of our doctors practising in Manitoba are from Great Britain. This is not going to continue. We should not have to rely on graduates from other areas in the future. We should be training graduates for areas that need doctors. If this is true, then we have got to do something about it. There are two things we can do something about, encourage young men and women to enter the practice of medicine and secondly, to meet, to organize the medical services so that they become more efficient, and it is, I think, just as great a need and probably greater need than just simply getting more doctors into medical centres or more prospective doctors into medical schools and more graduates is the better organization and better utilization of the personnel that we have.

COMMISSIONER FIRESTONE: Would you say, Doctor, that the elimination of the direct monetary relationship between doctor and patient would affect adversely the doctor-patient relationship?

DR. THORLAKSON: No, to the contrary I think it improves it.

COMMISSIONER FIRESTONE: Now, Doctor, it is been suggested to us by a number of medical groups across the country that the elimination of these direct monetary relationships between doctor and patient would affect adversely this relationship between doctor and patient. Do I understand, therefore, that you feel on the basis of your experience and that of your colleagues in

group practice that this is not justified by the fact of your experience?

DR. THORLAKSON: Dr. Firestone, it depends on how you would interpret your question and how you interpret the information which you have received. My interpretation is this, that the patient and doctor accept the fact that there is a direct financial obligation and a direct responsibility, and I accept in my brief there should be some minimum responsibility in addition to just paying a premium once or twice a year. It is quite different from what I imply from your question. I am saying in the groups carrying out this, of paying for this service, the doctor isn't directly involved. That's a little different from the way you put the question, there should be no monetary consideration between the doctor and the patient. I don't want to leave that impression, because I think it is very necesary that people should realize they have an obligation to look after themselves and pay for what they ask for whether they go into one office, a lawyer's office, a doctor's office or for any other service, there must be a personal responsibility which I have emphasized. How that responsibility is carried out, by direct payment or through insurance is up to the individual on a voluntary basis, but the mechanics of completing that transaction does not have to involve the doctor. That is what I would like to emphasize. I sensed in your question that there was a misunderstanding here, that there shouldn't be any relationship, money shouldn't come into it at all. It is not practical. Money has to come into it. I am talking about mechanics of

your situation.

DR. ROBINSON: [illegible]

My income which is taxable, that the patient and doctor meet the [illegible] need [illegible] mutual obligation and a [illegible] responsibility, and I [illegible] there should be some mutual responsibility in addition to just paying a premium once or twice a year. This is quite different from [illegible] your question. I [illegible] say, [illegible] the groups carrying out this [illegible] of paying for [illegible] services, [illegible] doctor [illegible] directly involved. That's a little different from the way you put the question. There should be monetary consideration between the doctor and the patient. I don't want to leave that out, because I think it is very necessary for people to realize they have an obligation [illegible] and pay for what they [illegible] doctor's office, a [illegible] any other [illegible]. There must be a personal responsibility, which I [illegible], and that responsibility [illegible] carried out, by [illegible] to the [illegible] but the [illegible] not [illegible]. That [illegible] I would like [illegible] [illegible] at all. [illegible]

completing that arrangement.

COMMISSIONER FIRESTONE: I am referring to the mechanics as well, Doctor. My question is if this money is paid by an insurance company or a cooperative or by Government acting on behalf of the indigents, in what way would such an arrangement affect the patient-doctor relationship in group practice?

DR. THORLAKSON: It would improve it.

COMMISSIONER FIRESTONE: Well, therefore, you feel that the source of money wouldn't affect the quality of medical practice?

DR. THORLAKSON: The source of money should not affect the quality of medical practice one iota provided that source of money does not come from a monopoly, particularly a Government monopoly and Goverment dominated plan.

COMMISSIONER FIRESTONE: If it is a cooperative plan that includes the medical profession and other groups and the insured as well as Government, if a cooperative plan, would that affect medical quality?

DR. THORLAKSON: I believe Government has to get in it and we as citizens have to be prepared to play our part and work in cooperation and in partnership with the Government, not as an opposing force, but as a force working towards a common need. There should be no conflict of interests here. We are concerned with the welfare of the patient. We are not concerned with establishing political ideas. We are directly concerned with looking after the patient. This requires organization. This requires money. Every segment of the society, the

COMMISSIONER KAMBOLOUS: I am informed by the members as well, doctor, the question is if was they is paid by an insurance company or a corporation or [illegible] according to [illegible] of the contracts, to what would such an arrangement affect the patient-doctor relationship in group practice?

DR. THOMPSON: It would improve it.

COMMISSIONER KAMBOLOUS: Well, therefore, you feel that the source of money would affect the quality of medical practice?

DR. THOMPSON: The source of money should not affect the quality of medical practice one iota provided that source of money does not come from a monopoly particularly a Government monopoly and Government [illegible]

COMMISSIONER PETERSON: If it is a [illegible] carrier groups and the insured as well as Government, if a cooperative plan, would that affect medical quality?

DR. THOMPSON: I believe [illegible]

[illegible] where the government, not as an opposing force, but as a force working towards a common goal. There should be [illegible] of interests here. We are concerned with the welfare of the patient. We are not concerned with [illegible] medical fees. We are strongly concerned with [illegible] after the patient. This requires cooperation, [illegible] requires money. [illegible] of the [illegible], the

taxpayer who is fortunate enough to pay taxes should accept his responsibility and be willing to see that part of his tax money goes to help less fortunate members of our society. Every group should be involved. This is what I would like to emphasize, Mr. Chairman, that voluntary, when we are on this point, that voluntary agencies and private agencies, they mirror public opinion, and this should be of great help to the Government. The Government's job is to encourage citizens to be self reliant and free and make decisions, at no time to control, conduct and regiment the actions of free men.

COMMISSIONER FIRESTONE: Doctor, may I compliment you on what you say about the welfare of the patient. It is a wonderful attitude and we congratulate you for your views. Thank you.

COMMISSIONER STRACHAN: Mr. Chairman, as Dr. Thorlakson may realize I am a native of Hamiota Municipality and have a birth certificate on me to prove that. I might also say that I well remember the day Dr. Ed Hudson's parents were married. There is one feature regarding the Hamiota Hospital that I think might be mentioned here, Mr. Chairman, and that is something referred to more than once in this hearing, the fact that Hamiota Hospital has accommodation for a local dentist. I wonder if, Dr. Thorlakson could expand on that feature.

DR. THORLAKSON: It has accommodation for ---?

COMMISSIONER STRACHAN: Local dentist, the dentist has his office in the Hamiota Hospital.

DR. THORLAKSON: I have no comment on

that. I see no objection to that arrangement provided there is no other dentist in the town or the area. There is no particular reason why he should have his office in the hospital, in a small hospital any more than he should have it down a block away. It depends on the local situation. The need in a small hospital, the need for dental services to hospital patients is very small and the dentist could go to the hospital as well as the doctor can go to his patient there. It is purely a local arrangement and I am sure the arrangement Dr. Hudson made and the community has made is very satisfactory providing there is only one dentist in the community.

COMMISSIONER STRACHAN: It has been referred to as a means of encouraging your dentists to go to outlying communities where there is no dentist, if accommodation were provided in the hospital there would be a greater possibility of him going there either permanently or part-time.

DR. THORLAKSON: That is my point.

THE CHAIRMAN: Dr. Thorlakson and Dr. Strachan, I think the discussion of dentistry at this stage is not too relevant to the situation that is before us at the moment, and with your permission I think, we have other delegations to hear, and we might get into many areas that are of interest, but not necessarily relevant.

I want to say on behalf of the Commission how grateful we are to you for having accepted our invitation and for your very lucid remarks here this morning. We welcome you here as one of the outstanding physicians in Canada and an ornament to the profession.

[illegible] popular, in a small hospital any one [illegible] have it down a block away. It depends on the location. The need is a small hospital, and need for dental service to hospital patients is very small so the dentist would go to the hospital as well as the [illegible] go to his patient there. It is purely a local arrangement and I am sure the hospital [illegible] the [illegible] community has made [illegible] satisfactory provision [illegible] only one dentist in the community.

CONTRIBUTORY SYSTEM. It has been suggested to me as a means of encouraging poor dentists to go to outlying communities where there is no dentist, if accommodation were provided in the hospital there would be a greater possibility of him going there [illegible] or permanently.

DR. [illegible]: What is my point.

THE CHAIRMAN: Dr. [illegible] and Dr. [illegible]. I think the discussion on [illegible] has not come to an [illegible] to the [illegible] on the [illegible], and with your permission, I think, we have other delegations to meet, and we might get [illegible] some [illegible] of [illegible]. We can [illegible] at [illegible].

I want to say on behalf of the Commission now [illegible] to you for having [illegible] and for your very good [illegible] we welcome you here as one of the outstanding [illegible] in Canada and an [illegible] to the profession.

DR. THORLAKSON: Thank you, Mr. Justice Hall.

THE CHAIRMAN: The next submission is from the Association of Hospital Administrators of Quebec.

SUBMISSION OF

THE ASSOCIATION OF HOSPITAL ADMINISTRATORS OF QUEBEC

APPEARANCES:

REVEREND FATHER H. BERTRAND

DR. C.A. GAUTHIER

DR. P. LAPLANTE

MR. P.F. OLIVIER

---EXHIBIT NO. 227: Submission of the Hospital Administrators of Quebec.

THE CHAIRMAN: We appreciate your allowing us to put you over from 9:30. We are grateful to you for having consented to that, for the reason of Dr. Thorlakson. A research staff is here to consult with him and he has to leave for Winnipeg as soon as possible. We appreciate the fact you consented to stand by.

DR. LAPLANTE: Mr. Chairman, our Association of Hospital Administrators is very happy to be able to meet the needs of the Commission for you. I should like to introduce the members of the delegation here this morning. I should like to introduce the Reverend Father H. Bertrand who is Director General; our Vice-President, Mr. Paul Olivier; our Secretary General Dr. Charles A. Gauthier. We have asked Dr. Gauthier to be kind enough to act as spokesman and to submit this brief himself.

THE CHAIRMAN: Dr. Gauthier.

DR. GAUTHIER: Thank you, Mr. Chairman, madam, gentlemen. With your kind permission the first

S U P P L E M E N T

[illegible]

[illegible]

[illegible]

[illegible]

D. T. [illegible]

[illegible]

---PAPERS NO. [illegible]: Discussion of the Hospital Administrators of Canada.

THE CHAIRMAN: We appreciate your allowing us to put you over from yesterday. We are grateful to you for having consented to work, for the success of the Conference. A research staff is here to consult with you and I am sure to leave or Wednesday as soon as possible. We appreciate the work you consented to assume.

DR. [illegible]: Mr. Chairman, our Association of Hospital Administrators is very happy to be able to meet the needs of the Commission for year. I should like to introduce the members of the association sitting behind. I should like to introduce the Reverend Father H. Tortorad who is Director General, our Vice-President, Mr. Ron Clayton, our Secretary General Mr. Charles A. Gaudry. We have asked Dr. Gaudry to be kind enough to act as spokesman and to submit this brief herewith.

THE CHAIRMAN: Dr. Gaudry.

[illegible]

words are going to be in English, again also with your kind permission, not the last word but the next words are going to be in French.

We have constructed our brief on certain, which we think basic and fundamental ideas. We would respectfully submit that we proceed in the following manner if agreeable to the Commission. We would like to read in French a general wide sweeping summary and then follow that by recommendations and then offer to your attention what we think could be priorities in any development of medical services for the Canadian people. If it is agreeable to you, we will proceed that way. Thank you, sir.

The main principles on which we have based ourselves in setting up this brief, first, were our our basic operational concepts of hospital operation. We believe that three main purposes, care, teaching and research are important, but it is still more important for each of these points to be upheld and maintained in its appropriate place, to the effect that teaching should not have priority over care, and that research should not reduce teaching to the third place. The main objective of the hospital is the patient, and this should be constantly borne in mind as the basic fundamental and prominent idea. We believe, however, that these three objectives have a certain inter-relationship between them to the extent that the hospital should care for the patient to the same extent. We believe as an Association that it is almost impossible to conceive of a hospital without teaching. The exercise of these three functions in their due order of priority in our opinion offers the best possibility

for success with respect to the quality of care given, provided this is done in such a way as to have as much as possible local economy and the free exercise of the right of proprietorship. We believe this because this system has already proven itself, not only by the competence of the people, but it has involved in it also the results attained. This is the basic cornerstone of our brief. We stress this very much as the general directing guiding idea. We stress the need for teaching and the preparation of qualifications in all the disciplines of hospitalization. Such preparation is indispensible to maintain or increase and improve hospital services. The authorities should respect and protect the right of the hospital, the proprietorship and the exercise of this right and should avoid any undue or useless control over these institutions.

c/ss

We will recommend that there should be study, revision and amendment made to Federal Bill 320 and these amendments should be guided toward the exercise of a more extensive and more effective local economy.

The Association will recommend for this purpose there should be a joint Federal-Provincial conference to assist the experience required up to now and to improve hospital insurance before dealing with health. One of the primary concerns of research expressed in this brief is to bring out the vital importance of preparing of competence in the hospital sectors and to assist and maintain by appropriate specialists the necessary structure. It would be useless to try to improve health and to increase hospital and to promote progress of medicine if there were no preparation which would be financing of teaching

for persons with respect to the quality of care given, provided this is done in such a way as to have a reasonable local economy and the free exercise of the rights of proprietorship. We believe this has been partly already proven itself, not only by the cooperation of the people, but in the involved in the plan the results are more this is the basic consideration of our plan. We therefore this very much as the general directing guiding idea. We express the need for teaching and the promulgation of education in all the disciplines of hospital care. Such preparation is indispensable to maintain or improve the improve hospital conditions. The authorities should respect and protect the right of the hospital, the proprietorship and the exercise of this right and should avoid any undue or useless control over these institutions.

We will recommend that the Ministry of Health, Aviation and Government have to Federal Law 320 and these amendments should be guided toward the interests of

The Consideration of Proposals for

this purpose there should be a joint Federal-Provincial conference to result the experience regarding by law and to improve hospital insurance before drafting other costs. One of the practical concerns of representatives in this bill is to bring out the vital importance of preparing of documents in the hospital services and to enable the rules and by appropriate provisions the necessary authorities it could be welcome to try to improve health and to increase hospital and to consider proposals of health as it seems more appropriate in which would be increasing of hospital

facilities in the Province of Quebec and we stress this particular point.

In the Province of Quebec most of the administrative authorities in the hospitals were trained by the Hospital Committee of Quebec. We had 83 graduates and we can add to this 31 medical directors we graduated from the school and we should not overlook the new initiative which has just begun, namely, a financial course in hospital administration. Through these thirteen registrations up to now in this course, this is only a small picture of the educational activity of the Committee of Quebec Hospitals who have come to more than 8,000 people. Our Association stresses that teaching and research are the basis of the quality of the care given. Our Association recommends that the high quality of care in research must be retained and subsidized. The hospital system of the Province of Quebec; after a long time now, this system, over the past twenty years 86 hospitals have been constructed; 46 were religious and 40 secular, eight of which are of religious participation. There was a report made on the thirty hospitals in Quebec which have a capacity of 10,000 beds and shows that the public demand for hospital care has considerably increased during 1961, but the hospitals have still maintained the quality of care given previously.

There is no question that the present quality of nursing depends on the contribution to that care furnished by the hospital. The main concept of nursing is, in our opinion, to give the best possible care of patients and to promote the progress of medicine. Of course, the quality of the nursing care depends to a very large

Province of Quebec and we can see this

In the Province of Quebec most of the

by the Hospital Council so of course, it has 5' problems and we can add to this 3' medical directors we combated from the Council and we should not overlook the Administrative which has just again, newly, a different course in

Going up to now in this course, this is only a small glimpse of the medical activity of the counties of Quebec Hospitals. We have come to more than 5,000 cases. Our Association discusses that teaching and research are the basis of the quality of the care given. Our association concerns that the Hospitals have to come in. Research must be received and considered. The hospital was, of the

the past twenty years 60 hospitals have been established; 40 more hospitals and 10 sanitary, eight of them are of contagious particular. There was a report made on the

beds and where such the public is demand for medical care and consultation increased during 1961. But the hospitals have still maintained the quality of care given previously. There is no question that the general

quality of nursing depends on the co-ordination in that care controlled by the hospital. The main concept of nursing is co-operation to give the best possible care of patients and to promote the progress of medicine. Of course the quality of the nursing care depends to a very large

extent on the training given by those who trained our nurses. The Association goes on in favour of nurses to grant them higher degrees and recognize them and we recommend this to the Commission. We feel nurses attached to hospitals should remain because the fundamental elements of nursing can be acquired only at the bedside of the patient. Our Association also recommends the installation of an accredited organization of nursing schools which will include the professional associations in the field of nursing care.

Mainly our Association states with respect to the patients that it is not only possible but desirable to have a psychiatric service included within the general hospital service. Moreover, our Association also believes that the mental patients should be able to mix with other patients so they do not feel isolated from society.

Our Association considers it necessary to have external out-patient clinics in the hospitals, they have been organizing for some time now and give very signal service and it will be called upon to give the greatest service to a growing population. These should be maintained and integrated in any program dealing with public health. However, we stress the fact that they alone cannot be expected to operate at a financial loss.

With regard to hospital economy, our brief observes that in detail the Government can pay patient costs without encroaching upon a hospital's economy. This is all right in theory, but, frankly speaking, we say we do not see how this can be done. Our Association

The Association does not in favour of nurses so that their degrees and recognize them and we recommend this to the commission. We feel nurses advanced

of nursing can be acquired only at the hands of the

of an accredited organization of nursing schools which will include the professional associations in the form of

Nobody our association starts with respect to the patients then it is not only possible but reasonable to have a psychiatric service included within the general medical service. Moreover, our Association believes that the mental patients cannot be able to mix with other patients so they do not feel isolated from

The association, considering it necessary to have external consultant clinics in the hospitals, have been going along for some time now and give very urgent service and it will be called upon to give the practical nurses in a growing profession. These should be methods and transport in an area of nursing such public health. However, in cases the first time they place nurses be expected to operate on a financial loss.

With regard to hospital economy, our

Nova Scotia all nurses in hospital, we, hopefully, do not do not see how this can be done. Our Association

recognizes the need for certain control, it recognizes the need for the Government's presence in this control but in our view this control should be exercised within a certain place regarding certain procedure and it should avoid parallel techniques.

With respect to health insurance, our Association is in favour of health insurance. As to its application, we are opposed to any regime of socialist medicine or state medicine. We favour, rather, a premium embodying full cooperation with the medical profession and the administration. We believe the Government control has already imposed its programs. This, however, does not stop research and obligation even by the state of social measures which are desirable for the true needs of the population. However, such measures should be established not by sudden erratical procedure, but progressively by steps which would adapt to the needs of the general population and it would also be adapted to the financial needs of this great country.

You will see certain repetitive things in the recommendations here, but with your permission I will now make our general submission.

We recommend:

1. That the role of the State remain supplementary without becoming substitutive, for it is possible and in the interest of all to maintain and uphold the private enterprise and the initiative of the hospitals.
2. That this be recognized and also the existence of the three aims of the hospital and their hierarchy (care, teaching, research) and their interdependence through

interaction, for to promote one is to promote the betterment of the others.

3.a) That governments recognize the need for the teaching of skills and put it into operation to uphold and maintain, by means of adequate subsidies, applicable to research and teaching, competent, qualified and tried organizations.

b) That the necessity for hospital personnel to be constantly trained and perfected be recognized and that every measure relative to health provide for and sustain this point of view.

c) That the authorities concerned support and encourage capable organizations, through specialized and intensive instruction, and through research into training skills in all branches of the medico-hospital complex. In view of the need for and the importance of training on one hand and the high cost of this training on the other, that governments support competent organizations which have extensive training programmes and a competent and adequate faculty able to cover the numerous aspects of the medico-hospital complex.

d) That the different elements in the initiation into hospital work be regarded by the authorities as one of the sources of progress and of excellence in hospital care and that this branch of instruction be maintained and extended.

4. That the authorities recognize in research (in hospital and other administration) the means of improving necessary instruction and of promoting thereby excellence in hospital care.

5. That excellence of care, of instruction, and of hospital research in the Province of Quebec continue to be recognized, maintained and supported.

6. That legislators take into account services rendered and the contribution made by religious hospital communities and that they keep in mind the canonical demands of these communities in the elaboration of any legislation liable to affect the hospital.

7. That the authorities recognize significant voluntary projects and that they respect the right of private property which has made possible the actual state of affairs with regard to all its projects and its qualities.

8.a) That the authorities encourage the training of and addition to all categories of hospital personnel through substantial assistance to the schools concerned.

b) That nursing schools remain attached to hospitals so that personnel trained there acquire the knowledge and clinical experience which constitute the essence of this profession.

c) That the university schools of nursing be helped and recognized in the matter of obtaining higher degrees in the field of hospital care.

d) That the authorities concerned devote special attention to the qualitative and quantitative development of equipment in nursing schools (most particularly their libraries) and encourage diversification of instruction in this field.

[illegible] in the Province of Quebec continue [illegible]

That legislators take into account [illegible] and the recommendations [illegible] hospital committees and that they keep in mind the comments of these committees in the elaboration of any legislation liable to affect the hospital.

That the [illegible] recognize significant voluntary [illegible] and that they respect the right of private property which has made possible the [illegible] of [illegible]

That the government [illegible] addition to all categories of hospital personnel [illegible]

[illegible] of this problem.

That [illegible] recognized in the [illegible] higher degree [illegible]

That [illegible]

9.a) That in any measure aimed at improving the health of the population, the authorities neither neglect nor minimize the importance of the psychiatric aspect of the health of a people.

b) That any legislation on the subject of mental health, not only attack the problems of mental sickness as such, but in addition, keep in mind the sociological realities of the environment to which it applies.

c) That general hospitals be encouraged to initiate certain psychiatric services within their organization and to integrate these services into their general structure.

d) That the authorities bring particular care to bear on the qualitative and quantitative training of psychiatric personnel.

10. That the authorities concerned make a complete study of the number and distribution of hospital beds, taking into account the needs of the present and of the foreseeable future for populations and regions.

11. That everywhere possible, each hospital organize within its administration a pharmacy and therapeutic committee to draw up and maintain from day to day an adequate and satisfactory pharmacopoeia for all interested parties.

12. That outside clinics in hospitals be maintained, sustained and increased with the adjunction of laboratory and radiology services, while avoiding the state of being constantly and seriously at a budgetary deficit.

13.a.) That the authorities respect and protect the property

(iii) [illegible] should be improving the health of the poor which, the authorities believe neither neglect nor minimize the importance of the psychiatric aspects of [illegible]

that any legislation on the subject of mental health not only attack the problem of mental disorders as [illegible] but [illegible] the realities of the environment to which it applies.

c) That general hospitals be encouraged to [illegible] certain psychiatric services within their organization and to integrate these services into their general [illegible].

d) That the authorities [illegible] particular care be taken on the qualitative and quantitative training of psychiatric personnel.

Thus the authorities concerned make a concrete step [illegible] taking into account the needs of the present and of the future, and a future for psychiatrists and patients.

Within the [illegible] a pleasant and therapeutic [illegible] be used by and welcome from day to day as [illegible] and satisfactory [illegible] for all.

That services [illegible] in hospitals [illegible] and integrated with the activities of [illegible] and [illegible] services, while avoiding the [illegible] of [illegible] and [illegible] or a [illegible] [illegible].

(iv.) [illegible] the [illegible] methods are [illegible] the [illegible]

right of the hospital and the free exercise of this right by avoiding the exercise over institutions of undue or pointless control.

b) That there be study, revision and amendment of Federal Bill 320 and that these amendments be directed not only towards the actual maintenance of a certain relative autonomy but especially towards the exercise of more extensive and more real local autonomy, and this, within the framework of constitutional exigencies.

c) To this end, there be a federal-provincial conference to determine the position with regard to actual experience up to now and to improve hospitalization insurance before tackling the general field of health insurance.

Priorities

1. To guarantee the success of what already exists at the present moment before trying new fields of action.

2. To maintain and amplify any measure relative to preventive medicine.

3. To aim for the maintenance and, on certain points, the improvement of the quality of services. Any measure tending to lessen the excellence of services must be automatically rejected.

4. To maintain and encourage administrative, professional and academic autonomy of hospitals according to known local needs.

5. To maintain, encourage and promote instruction and

research in the field of hospital administration.

6. To determine means of rendering more feasible, for existing or added hospital beds, the possibility of quicker admission to hospital.

7. To encourage the maintenance and expansion of out-side clinics in the hospitals and most particularly to make use of their diagnostic facilities such as laboratories and radiology departments.

We believe that priority should be given to endeavours to find and to maintain and promote teaching and research in the field of hospital administration, so as to create the necessary competence in each of the particular disciplines that fall within the general field of hospital administration. We also believe that in any future plan of action the means should be determined to increase existing bed space, and to improve the facilities presently available. Finally, we feel that any plan designed to maintain the quality of care, or to improve it, should provide for the extension of out-patient clinics, with the addition of diagnostic technology, such as X-rays, etcetera.

We will answer to the best of our ability any questions put to us, and they will be answered by one of us four, according to the general field of action they do pertain with.

THE CHAIRMAN: There are some questions I should like to put to you, Dr. Gauthier, and I shall begin with your first recommendation. In that recommendation you state that it is possible and it would be desirable to maintain private initiative. We heard on Friday

[illegible]

6. To determine needs of providing more facility for outside, or where hospital beds, the possibility of outpatient admission to hospital.

7. To encourage the maintenance and expansion of outside clinics in the hospitals and most particularly, to make use of their diagnostic facilities such as laboratories and radiology departments.

We believe that emphasis should be given to endeavours to find and to maintain adequate teaching and research in the field of hospital administration, so as to create the necessary competence in each of the particular disciplines that fall within the general field of hospital administration. We also believe that in any future plan of action the means should be concentrated to increase existing bed space, and to [illegible] the facilities presently available. Finally, we feel that any plan designed to maintain the quality of care, or to improve it, should provide for the extension of out-patient clinics, with the addition of diagnostic radiology, such as X-ray etc.

We [illegible] ability and questions [illegible] by one of us, [illegible] they do [illegible].

THE CHAIRMAN: There are some questions I should like to ask you, Dr. [illegible], and I shall begin with your first recommendation. In this recommendation [illegible] you [illegible] [illegible] voluntary [illegible] initiative [illegible]

afternoon that there were several private hospitals in Montreal, and in the neighbourhood, that are not supervised or accredited. Is your Association concerned with these private hospitals, or with the quality of the treatments given in those private hospitals?

DR. GAUTHIER: With your permission, Mr. Chairman, this question can be subdivided into two aspects. One which deals with the treatment of the patient and the progress of medical practice, and secondly the purely administration aspect. I would say a few words as regards the medical aspect. Medically it is true that there are quite an impressive number of private, not small or not that small, hospitals which have been accredited by the Canadian Medical Council. Our Association has taken several steps so that this situation, which has to be remedied, be remedied as soon as possible. Through our teaching and through the teaching schools considerable efforts have been made along those lines. On the part of the physicians concerned, as regards the administration of those small hospitals we have also been concerned with it, but I think by your leave, sir, that Dr. Laplante, our President, should speak on that and amplify it.

DR. LAPLANTE: Indeed, Mr. Chairman, though our Association is not yet an old Association, it is in existence only since a few years. We have had this month a symposium where we had approximately 125 of our members in order to study the budget to be submitted with respect to 1961, and our President, Mr. Olivier, took upon himself to educate the people and inform them how to prepare their budget. That is only one aspect, one facet of our

afternoon that there were several private residences in Montreal, and in the neighbourhood, that are not kept visited or accredited. Is your association concerned with [illegible] private hospitals, or with the quality of the treatment given in those private hospitals?

[illegible]

Mr. chairman, this question can be subdivided into two aspects. One which deals with the treatment of the patients and the progress of medical practice, and secondly the purely administrative aspect. I would say a few words regarding the medical aspect. Medically it is true that there are quite an impressive number of private, not small or not great, hospitals which have been accredited by the American Medical Council. Our association has taken several steps so that this situation, which has to be remedied, be remedied as soon as possible. Through our association and through the Quebec Medical Association efforts have been made along these lines. On the part of the specialists concerned, as regards the administration of these small hospitals we have also been concerned with it. But I should say that here, then in Quebec, one [illegible]. Should people be turn out overnight it.

[illegible]

[illegible] our association in the [illegible] and [illegible]. It is in existence only since a few years. We have had this month a meeting where we have approximately [illegible] of our members in order to [illegible] by budget in a manner which [illegible] to life, and our recommendation, Mr. Oliver, has been [illegible] to increase the [illegible] that we be put [illegible] budget. Much is only one aspect, the lack of one

administrative concern. We encourage to the best of our ability accreditation of hospitals.

THE CHAIRMAN: Your organization, and we respect your right to say so, emphasizes the desirability of private enterprise in the hospital field. Does that mean that you favour the existence of such a system of small private hospitals, not subject to inspection, not subject to accreditation, and spoken of in the way, I know you were not here, but spoken of quite critically by those of the medical profession who were before us, that is the obstetricians and gynaecologists, who appeared to take a very serious view of that type of hospitalization, so-called private enterprise in that limited way, and without any real means of controlling the quality of service in such a hospital.

DR. GAUTHIER: Before I answer directly that question, sir, I should say that when we speak of private hospitals we do not mean only small hospitals.

THE CHAIRMAN: Yes, I understand that. I am just referring to small private hospitals.

DR. GAUTHIER: However, we definitely take the stand to the effect that any hospital must tend towards a system of visits which would improve both the quality of care and treatment given and the management and administration, and no hospital, however small, can skip this, and we encourage them all to take all steps necessary to invite visits and correct their methods, to make them acceptable and to make sure of the quality of the treatment. We recommend and promote, and we desire, that they submit themselves to inspection, and if possible to education.

THE CHAIRMAN: We were told that one of the reasons that these small and perhaps inefficient hospitals, to be very charitable in the word I am using, as described by the obstetricians and gynaecologists, one of the reasons for their existence is that many of the general practitioners in Montreal do not have access to the larger hospitals, whether municipal or otherwise, and it is in that light that I put the question to you gentlemen as administrators of the hospitals.

Is it a fact that because hospitals are closed, or partially closed to some doctors that you have a second, or an inferior grade of hospitals come into being, because all doctors couldn't bring their patients to the general hospitals?

MR. OLIVIER: Mr. Chairman, madam and gentlemen, I think the point which you have just raised, Mr. Chairman, is indeed a serious one. We do not accept the idea, the expression of closed hospitals administratively in general, but in practice I at least as an outsider --- The quantity of available beds perhaps does not permit a great admission of general practitioners. Our hospitals, at least in the metropolitan area, accept more and more the opening of services which we call general practice, but we are only beginning in this field. The Association of Hospital Administrators has naturally viewed with pleasure the somewhat larger admittance within several hospitals, large or small, of this particular field of medicine. However, one must recognize that the doors are still closed. If there were a threat towards opening it, it would arise from the fact that a lot of hospitals cannot

be more generous. Perhaps the cost of some manner of operation, or certain administrative structure of our hospitals didn't permit them to accept their patients. Hospitals which have thus developed have, as you mentioned earlier, perhaps at the beginning lacked the supervision which should have prevailed, and therefore in fact we were content with obtaining from the municipality, or from the City an organization permit, a permit which was delivered by the health authorities, which didn't enter into the full detail of the requirements. Since they were done by what I would call our alma mater, the Quebec Hospital Association must be mentioned. We must say that over the last few years the Committee has looked very carefully into these small hospitals. In fact, you will find in the Hospital Committee a number of small private institutions which had to submit themselves to the regulations made by the Hospital Committee, and those small hospitals wish to come within the framework of the Association and have had to submit themselves to an inspection. How they have been inspected I don't know, because I don't know all the work of the Committee. A number of small hospitals, private hospitals, completely private hospitals, managed and operated for a profit, because in the private institutions of the type you have mentioned it is always for a profit the operation is made, these have been subjected to certain standards and inspected. Unfortunately they have not all been. We as an Association lead those people to register with our Association, but what the conditions for their admission to our Association is, first of all competence in the hospital field. Also recognition of experience and

[illegible]

[illegible] hospital's [illegible] permit them to accept their patients

Hospitals which have [illegible] open wards, as you mentioned

[illegible]

which should have privileges, and therefore in such a [illegible]

conflict with obstetrics, from the municipality, or from the

[illegible]

by the health authorities, which often's owner into [illegible]

full control of the [illegible]. Since then we have [illegible]

what I would call one nine matter, the Quebec Hospital

Association must be mentioned. We have, my [illegible] over the

last few years, the [illegible] has looked very carefully for

to those small hospitals. In fact, we still have in the

hospitals (meaning a number of small hospitals) [illegible]

which had to [illegible] to the municipalities from by

the Hospital Commission, and those small hospitals which

[illegible] within the framework of the Association and have had

to submit themselves to an inspection. Now they have [illegible]

[illegible]

[illegible], [illegible] hospitals, [illegible] and

provided for a small [illegible] from private institutions

of course you have mentioned to in [illegible] for a public

the commission [illegible]. There have been [illegible] to [illegible]

[illegible] and [illegible]. Unfortunately they have not [illegible]

[illegible] in the Association have been [illegible] to [illegible]

with our Association, but that the [illegible] for [illegible]

[illegible] to our association in [illegible] and [illegible]

in the hospital field. Also [illegible] and

recognition of the responsibilities they have taken.

I think I have answered at least administratively as regards what we have done for the small institutions you mentioned.

DR. GAUTHIER: I think our Director General could offer something to explain what steps we have taken to remedy this state of affairs. It seems difficult to accept.

FATHER BERTRAND: I am of the opinion, Mr. Chairman, that no hospital should exist, that no hospital should be allowed which would not meet scientifically recognized standards. I think that is a clear and categorical answer.

Private hospitals which are members of the Quebec Hospital Committee, which it was my honour to direct up to last November, have all been inspected by physicians, by the serious and conscientious doctors and those doctors, a small number of the doctors, they were amazed at the manner in which those small hospitals were managed. There are not many of them, but the ones we have accepted were of the best possible quality, and met the scientific standards.

That, Mr. Chairman, is what I wish to say, not to add but to confirm.

THE CHAIRMAN: What supervision is there over hospitals which receive the hospital installments?

DR. LAPLANTE: The Director of Standards of Hospital Insurance for the Province of Quebec at present visits. There is a doctor in Montreal who devotes most of his time to this, and some of the hospitals which were

regulation of the responsibilities they have taken.

I think I have answered an inquiry cumulatively as regards what we have done for the small institutions you recommend.

General could offer something to explain what steps we have taken to remove this state of affairs. It seems difficult to accept.

CAPTAIN BERTRAM: I am of the opinion, Chairman, that no hospital should exist, that no hospital should be allowed which would not meet reasonably accepted standards. I think that is a clear aim

For the hospitals which are in charge of the Queen Hospital Commission, which it was my honour to direct up to last November, have all been inspected by

there cookies, a small number of the doctors. They were asked as the manner in which those small institutions

[illegible]. There are not many of them, but the ones we have inspected were of the most [illegible] quality, and not too [illegible].

Chairman, Mr. Chairman, in view of what is [illegible], not to and let us [illegible].

MRS. MACNAMARA: When [illegible] more over hospitals which receive the [illegible] [illegible]

MR. MCPHERSON: The principle of [illegible] of hospital insurance for the [illegible] at [illegible] Yukon. There is a scheme in [illegible] the [illegible] [illegible] to [illegible], and [illegible] of the [illegible] [illegible]

mentioned by the Association of Gynecologists and Obstetricians had, I am sure, already been visited. They have no regulations. They have no laws to prevent them, but the question is being considered now.

COMMISSIONER GIRARD: Mr. Chairman, in order to clarify the matter somewhat, I wonder whether there has not been some obscurity as regards the words that were used when the Gynecologists and Obstetricians Association mentioned small hospitals. I think, if they didn't say so openly, I think this involves small hospitals which do not receive hospital insurance, what have been called in English I think proprietory hospitals, and I think there was some confusion between the words proprietory hospitals and private hospitals. Maybe this would throw a different light on it, because the gynecologists and obstetricians mentioned small hospitals where people pay themselves for their care. Therefore, this involves hospitals which are not benefiting and do not receive hospital insurance, and they were surprised that so many people still registered with those hospitals and were to pay themselves for their treatment and care, instead of going into hospitals that receive insurance payments, so I think that most of the small hospitals on which some discredit and aspersions were cast fell within that category. I don't know if you have an opinion on this matter.

MR. OLIVIER: Mr. Chairman, Madam, I think you mentioned the fact this has to be recognized, the payment of hospital insurance by the Province of Quebec, and this service does not recognize the small private hospitals in existence at the time when the plan was

[illegible] Chow been to learn to present them, but [illegible] n is being considered now.

CHAIRMAN [illegible]: Mr. [illegible], in order to verify the [illegible] report, I [illegible] there has not been some observation or research [illegible] made in the [illegible] and observation [illegible] been mentioned small hospitals. I mean, if they [illegible] generally. I think this involves small [illegible] which do not [illegible] hospital insurance, that have been [illegible] application. Think from [illegible] hospitals, and I think there [illegible] some connection between the [illegible] and [illegible] conditions. To be [illegible] I would [illegible] a different light on it, because the [illegible] and observations [illegible] small hospitals are [illegible] by observations [illegible] other [illegible]. Therefore, this involves hospitals which are [illegible] and do possess a hospital [illegible] [illegible] they were [illegible] to [illegible] small [illegible] with [illegible] hospitals [illegible] [illegible] [illegible] and [illegible], [illegible] on [illegible] [illegible] [illegible] [illegible] small hospitals on which [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]. I don't [illegible] if you have an opinion on this matter.

[illegible]

I think [illegible] [illegible] [illegible] [illegible] [illegible] the [illegible] of hospital insurance by the [illegible] of [illegible] and this [illegible] [illegible] [illegible] [illegible] hospitals in existence at the [illegible] when [illegible]

instituted. There are still a certain number of hospitals which don't receive what we call financial contribution from the Hospital Insurance Service. As you mentioned the patients that go to these entirely private insitutions must bear the full cost. They may be covered by some insurance. In fact, the insurance doesn't cover it extensively. Perhaps they are in the position to support the cost of this. You say why do they go to these institutions? Why? I think that is the purport of your question, why people enter such hospitals when they don't receive the financial help they are entitled to as residents of this Province. The Government to my knowledge hasn't had sufficient time, as mentioned by our President, to perform inspections of private institutions and wasn't in a position to determine yet whether under the hospital standards they were acceptable or not. Secondly, even if the Government had done so, there would still, perhaps be some institutions for some reason of which we are not aware, would have been disallowed, so people go there for the simple reason, I think, that maybe they cannot be admitted elsewhere because at the time of the need for care there were not beds available or because the doctor has insisted they go there because it was only there he had facilities to give them hospitalization. I think that is the only logical answer on the subject.

COMMISSIONER GIRARD: To go one step further on this, not inquiry, but investigation, as to the state of affairs, let us assume that a hospital such as the ones we mentioned is inspected by someone from the Government to see whether it would be proper or not to

provide hospital insurance subsidation and it is decided that this hospital is not, cannot be recognized and does not qualify for hospital insurance, that hospital, if there are patients that go there and continue to pay for their treatment will continue to stay, so no one is responsible for the standards of treatment at that hospital. That is the point, that is the most important point. This hospital will continue to exist if patients want to go there they will go there if they have sufficient financial means or insurance to cover the treatment they will continue to go there, and they don't necessarily know the small hospital. The Government -- who is going to take care of the standards that have to be met for the proper treatment and care. As a resident of Montreal for a number of years I was considerably surprised at the figures given by the Association of Obstetricians and Gynecologists.

DR. GAUTHIER: Who is responsible -- in the field of history that which concerns the health of the population, who is responsible for the prophylaxis, for the treatment of the health of our population, at least to our mind, I think it falls to the Province. Who in the Province is responsible for that? That is the Ministry, the Ministry of Public Health. Whether that Ministry does so directly or by means of another Ministry or whether they delegate authority to one or more agencies, competent and qualified authorities, it nevertheless remains this is a Provincial responsibility in its substance, I think, at least.

COMMISSIONER GIRARD: As a hospital administrator what would you recommend for that state of affairs?

DR. GAUTHIER: Purely from the medical point of view I shall answer. Others will be able to expand on the matter of the administration. From the medical point of view, first of all, voluntary associations should continue to educate all those who are responsible for hospital care in that field and that sector. A system of well balanced education and progressively increased education should succeed in making them so that they would be acceptable where the Association holds standards that are high. These means should continue. Finally one could touch on a few more recommendations with regard to the laws of demand, so that the beds available in other hospitals may be vacated early so there would be less pressing demands as regards the hospitals. I don't know if anyone wants to add something from the administrative point of view. Mr. Laplante?

MR. LAPLANTE: The system of education which existed over the last forty years has always been a system of voluntary accreditation, and in fact, the progress has been quite considerable. We think that if hospitals who have it at heart and who are proud of their facilities, the system which we have at present will continue to do much to improve the situation. On the other hand there are some limitations and restrictions as regard the number of beds in the hospitals which can be accredited. With a minimum of 25 beds for smaller hospitals, quite obviously the hospitals, the Government authorities would have to protect the general public, and this would be done through appropriate legislation. Unfortunately in the Province of Quebec we don't have the Hospitals Act. There is a

Private Hospitals Act which should be revised, but there is no Public Hospital Act. That state of affairs could be remedied by the Government by inspecting these hospitals and operating by a system of licence.

MR. OLIVIER: Mr. Chairman, and madam, it is also a question, because on the same subject, what you must remember in the Province of Quebec in the beds of general hospitals, there are 81% of beds are accredited. That is quite something. That doesn't mean the remaining 17% is something which should be completely wrong, but still since we recognize the fact that the authorization of organization of private hospitals in such cities as the City of Montreal, now falls within the Department of Health of the City of Montreal and that the private hospitals could also have the Province remit to the municipality this obligation to inspect.

I think we should expect the municipalities to obtain satisfaction of hospital standards before authority to open such hospitals is granted to them.

COMMISSIONER GIRARD: Dr. Gauthier, or any one of your colleagues here, we have heard much from hearing of briefs coming from the various provinces, we have heard much of the use or the ill use of hospital beds. Patients were admitted in some departments on Friday and on Thursday and because some services and departments didn't operate over the weekend, consultations, analysis and so on were not made until the Monday. On the Tuesday you get reports. On Wednesday you may think perhaps surgery is going to be done. They are going to do something about it. So, in fact, five days have elapsed, five days since

Private Hospitals Act which should be revised, but there is no Public Hospital Act. That state of affairs could be remedied by the Government by inspecting these hospitals and operating on a system of license.

Mr. OLIVER: Mr. Chairman, and members, it is a suggestion, because on the same subject, that you may remember in the Province of Quebec in the beds of general hospitals there are 8% of beds are earmarked. [illegible] is quite something. That doesn't mean the remaining 12% is something which should be completely wrong, but still since we recognize the fact that the authorization of organization of private hospitals in such cities as the City of Montreal, now falls within the Department of Health of the City of Montreal and that the private hospitals could also have the Province remit to the municipality this obligation to inspect.

I think we should expect the municipalities to obtain regulations or hospital standards before authority to open such hospitals is granted to them.

[illegible]

or any one of your colleagues here, we have been much [illegible] from hearing of stories coming from the various provinces, we have learned much of the use or the lack of hospital beds. Problems were common in some conferences on hospitals and on Medicare and because some services and departments [illegible] over the months, conventions, analysis [illegible] made until the Monday. On the Tuesday [illegible] you may write personal [illegible] to be done. They are going to do something about it. Why in [illegible] like days have elapsed, five days since

the patient arrived at the hospital. He has occupied a bed there, and during that time there is a lengthy waiting list. Several groups have been rejected, we were wondering within the Commission what could be done for the better use of the available hospital beds in view of the fact of the lack of hospital beds because there is a lack of hospital beds that was stated last week and in the Province of Quebec, the worse lack referring to the number of hospital beds per capita.

DR. GAUTHIER: I will say a short word on the medical aspect and the use of services and the admission to the hospital and the others can answer to the administration aspect. It is true that for some time, a relatively short time in our province the fact of admitting a patient over the weekend, well, around the weekend, that is usually on the Friday or Saturday immediately preceding the weekend has raised a problem as to the expeditious discharge or the functions concerning the analysis necessary, pre-surgery or pre-diagnosis analysis. New hours of work, new contracts and a rather considerable shortage of technicians are such that the average duration of hospitalization has increased because the operation over the weekend is perhaps not as overall, the activity is not as efficient, uniformly efficient as the rest of the week. That is why our Association has recommended some time ago, particularly as regards technological personnel, technicians in the laboratory -- this was made somewhat complex lately, considerably complex in the field of medical secretaries where working hours have also decreased, in which the substitute wasn't as easy as it would have been desirable.

the patient arrived at the hospital. He was assigned a bed there, and during that time there is a lengthy waiting period [illegible] whether the examination what could be done for the better use of the ever-this hospital beds in lieu of the fact, the lack of hospital [illegible] there is a lack of hospital beds that was noted last week and in the minutes of Committee the worse case scenario, so the number of hospital beds

DR. GAUGHLER: I will say a short word on the modern space and the use of services and the admission to the hospital and the others can answer to the administration aspect. It is true that for some time, a relatively short time in our province the fact of admitting a patient over the weekend, well, around the weekend, that is usually on the Friday or Saturday immediately preceding the weekend has raised a problem as to the expenditure difference or the functions concerning the analysis necessary, pre-surgery or pre-diagnosis analysis. New hours of work, new procedure and a rather considerable shortage of technicians are such that the average duration of hospitalization has increased [illegible] the operation by a the weekend is somewhat [illegible], the activity is not as efficient [illegible] sufficiency on the end of the week. That is why our association has recommended some time ago, and [illegible] to [illegible] technological [illegible], centralization in the [illegible] -- this was more economic [illegible] considerably larger in the field of [illegible] conservation [illegible] also increase. It would be [illegible] as very as it would have been desirable.

Some hospitals have attempted to circumvent that difficulty partially by instituting a system of discharge and admission within the week, the active days of the week when the personnel is at full strength. This in part has been successful in some fields. The results weren't uniform in all disciplines and departments. From the strict medical point of view it appears urgent that the training of technicians in greater numbers, competent technicians should be available over the weekend, so that the laboratories and the radiologists don't relax over the weekend. In fact, illness does not relax over the weekend. That is one of the fields that seems most important for the time being. In regards to medical secretaries, which is also an important aspect, it is less urgently required than X-ray or laboratory personnel. I don't know if anyone wants to add a word with regard to the general administration of the hospital.

COMMISSIONER GIRARD: Could someone tell me something about the economic aspect of this problem? You have surgical rooms, surgical wards which you know full well how they cost, which are occupied five days a week, six or seven hours a day, X-ray departments which costs very, very much are used only on certain days and hours of the week. Perhaps someone would also mention this economic aspect, if something could be done, if they have replacement technicians? Nurses work a 24 hour day. You have a rotation of personnel, turn-over and so on. I mean this is done all the time. They work continually, 24 hours a day around the clock, seven days a week. Could this so costly department, could they not be used at full

partially by instituting a system of discharge and within the week, the seven days of the week when the [illegible] is at full strength. This in part has been [illegible] for [illegible] fields. The results weren't uniform in all directions and departments. From the strict medical point of view it appears urgent that the training of technicians in greater numbers, competent technicians should be available over the weekend, so that the laboratories and the radiologists don't relax over the weekend. In fact, illness does not relax over the weekend. That is one of the difficulties that seems most important for the time being. In regards to medical secretaries, which is also [illegible]

X-ray or laboratory personnel. I don't know if anyone wants to add a word with regard to the general administration of the hospital.

COMMISSIONER GIBARD: Could someone well me something about the economic aspect of this problem? You have surgical rooms, surgical teams which you know full well how they work, which are occupied five days a week, six or seven hours a day. X-ray departments which work very very seldom are used only on certain days and hours of the week. Perhaps someone would also mention this economic aspect. If something could be done, if they have replacements [illegible] Nurses work a 24 hour day. You have a rotation of personnel, turn-over and so on. I mean this is done all the time. They work continually. 24 hours a day around the clock, seven days a week. Doctors are overly conservative, could they not be used at full

strength and instead of having twenty surgical rooms have only ten used full time? Would that be possible?

DR. LAPLANTE: Yes, it quite obviously would be possible. Before we arrive at that we should like to have more people, more trained staff and personnel, more qualified people to do the work. At the present time I don't think there is a single department using technicians and even hospital professions, where we have enough personnel, in X-ray, for instance, it is a fact that there is much money invested in capital equipment. It is used only a few hours a week, but in 1962 in the limited working hours it is very difficult to have that with the number of technicians we have now. As to the surgery wards it might be a good thing. Perhaps many surgeons would be happy, in the Summer, for instance, to operate in the evenings rather than to work in the middle of the day, but I don't think we would have enough nurses or enough assistant nurses who would be prepared to work at night or in the evening, both in the laboratories and the X-ray departments. In addition when you work at night in the hospital you have to pay more. The economic question, the financial aspect, in order to provide that service, in order to make full use of the invested capital you would need operating funds for a greater, much more operating capital. You would have to ask for much more. It would be more expensive for the patient.

MR. OLIVIER: There are psychological phenomena here that shouldn't be overlooked. Namely what is overlooked, in the years 1900, 1910 the father was identified with his children and worked a fifteen-hour day.

[illegible]

Mr. Arnold: Yes, I quite appreciate [illegible] feature a matter to what we should like to have more [illegible] more trained staff and personnel, more qualified people to do the work. As the president has [illegible] technicians and over-all protections, where we have enough personnel, in fact, for instance, it is a fact that there is much money invested in capital equipment. It takes only a few hours a week, but in light of the [illegible] it is very difficult to have that [illegible] of trained men we have now. As to the surgery weeks it takes to a good thing. Perhaps many surgeons would be happy, in our Summer, for one week, to operate in the evenings rather than to work in the middle of the day, but I don't think we would have enough nurses or other ancillary people who would be prepared to work at night in the morning, both in the laboratories and the X-ray departments. In addition when you work at night in the hospital you have to pay more. The economic position, the financial aspect, it cannot be provide that [illegible], we have to make full use of the improved medical [illegible] facilities for a greater much more [illegible]. You would have to [illegible] more. It would be more expensive for the patient.

[illegible] I think it is one [illegible] that should be overlooked. [illegible] when [illegible] to the [illegible]. Info the [illegible].

It has evolved even more rapidly for hospital institutions. You must recognize the employees in hospitals today have cast their eyes towards this very limited labour market and also the nurses. Tell us how many nurses we have lost because they were attracted by better working conditions than given in the hospitals. If such is the case and if we could allow -- we could work seven days a week, we could no longer do so now, because we no longer have the personnel which has been attracted to other fields, for the same activities in other fields, in industry, in commerce, in municipal departments. We should be very happy to see our institutions working seven days a week and we feel convinced we could give better help but we feel that with the present staff available we cannot do any better.

COMMISSIONER GIRARD: That is not necessarily nursing staff only, the nurses have always risen to the occasion at the expense and sacrifice of themselves. I do not think it would be the nurses.

MR. OLIVIER: I agree, it does not only involve nurses, it involves all the personnel and the personnel thinks of personal freedom and liberty which is expanding all over the world.

COMMISSIONER GIRARD: Now, what of the patient clinics? Several briefs we have looked at say that if our patient clinics could operate free of charge, if the patient clinics came under the Hospital Insurance Act we could save many hospital days. What do you think?

DR. GAUTHIER: On the general level I should like to make one or two comments. I think that the

[illegible] better working conditions than given in the hospitals. If such is the case and if we [illegible] seven days a week, we [illegible] no longer [illegible] because we no longer have the personnel which has been [illegible] to other fields, for [illegible] in industry, in [illegible] departments. We should be very [illegible] working seven days a week and we [illegible] give better help but we feel that [illegible] we cannot do any [illegible]

[illegible] That is not necessarily [illegible] The nurses have always [illegible] and sacrifice of [illegible] would be the nurses.

[illegible] I agree, it does not only [illegible] and the [illegible] which is [illegible]

[illegible] Now, what of the [illegible] looked at any time [illegible] if [illegible] you think?

[illegible] the general level I [illegible] I think that the

answer does not apply uniformly to all areas of the Province and this requirement is not uniform depending on whether you are dealing with an urban sector or not. In some sectors we have witnessed increases in out-patient clinics which have been quite marked; in other sectors the increase has been very small. Generally in comparable figures for the first three months of 1961 - 1962 we see that some figures in some of these sectors have increased attendance at general out-patient clinics of 22%. During that time the emergency clinics increased by 52% and the trauma clinic also. The major part of the out-patient cases, emergency and trauma are only partly covered by insurance. However, a good number of hospitals in urban centres have established temporary treatment sectors within out-patient clinics so as to avoid hospital and the out-patient clinic has organized or has perhaps to be a unit within the whole unit which is the hospital. If attendance increased it means that the out-patient clinic should increase the staffs, personnel and so on, and also the equipment. Also for the time being it seems as regards available services these out-patient clinics are inadequate in view of the increase in attendance. The greater they are the better they are equipped with competent, qualified personnel and they will be in a position to meet the requirements without depressing the numbers of outside positions since these are patients treated either by other doctors or charitable institutions or who come to the clinic because of serious accidents.

COMMISSIONER GIRARD: Dr. Gauthier, you have only answered my question in part. Are you aware

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whether men are dealing with an urban center or not. In
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visits which have been quite marked; in other centres the
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that some figures in some of these centres have increased
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specialist services these out-patient clinics are increasing
in view of the increase in attendance. The greater they
are in proportion to the population with consequent, qualified
personnel and they will be in a position to meet the
requirements without disrupting the numbers of outside
general practitioners or see possible increased either. By other
centres or constitute increasing in the community.

[illegible]

[illegible] and then only [illegible] by question [illegible]

of the fact that patients are sometimes hospitalized for different reasons and they can occupy a bed for three or four days for something that might be done better in the clinics perhaps at one-third or one-half the cost?

DR. GAUTHIER: In some sectors, yes, emphatically. There are certain medical disciplines which in some portions of our country we have 10% to 12% of cases where we could avoid hospitalization.

COMMISSIONER GIRARD: Are you in favour of having the cost of out-patient clinics coming under the Hospital Insurance Act? Would you recommend that?

DR. GAUTHIER: Perhaps Mr. Laplante could answer that. We have mentioned it in our brief.

DR. LAPLANTE: Yes, we recommend that the hospital be for the operation of the out-patient clinics and we believe that there could be a good number of new patients who could be examined or where diagnosis could be made without requiring hospitalization. In what manner can this be achieved and paid for? You would have to take into consideration also the fact that in the centres of the Province, other provinces where there are now out-patient clinics, that that same service would be available and could be given to the citizen in that area also just as well as if they lived in an urban area where there are many hospitals with out-patient clinics.

COMMISSIONER GIRARD: Thank you, Dr. Gauthier. I should like to speak for a few minutes about nursing, but since our time is short and my colleagues also have questions on other problems perhaps we can go back to nursing later.

COMMISSIONER BALTZAN: Dr. Gauthier, I am going to limit my few questions to you -- to your belief and of benefit to your hospitals mainly in relation to the recent implementation of the Hospital Insurance Act. My questions will be short and I do not want, to save time, any full explanation. Let us try the first question. What limitations have you experienced for increasing your accommodation as they be needed? Have you the same difficulties or more difficulties if you should want to increase your hospital accommodation?

DR. GAUTHIER: Well, sir, in the previous years when a local hospital administration found out that it could not cope with the laws of offer and demand and it was indicated to increase capacity in the hospital, the board of administration would sit down, study the matter, make out the figures, turn out the plans, give contracts and start building and that was that. Nowadays you can sit down and analyze it and decide to build and then it has to be approved.

COMMISSIONER BALTZAN: And so far have you experienced any difficulty in getting that approval?

DR. GAUTHIER: Some hospitals did have difficulties, others decided to build by themselves. It has been a vast and far-reaching gesture at times covered by a recoup, at other times locally absorbed with great difficulties and worries.

COMMISSIONER BALTZAN: Would you apply the same sort of position in relation to the requirements of a hospital for renovations or refurnishing for the freedom of action or the means to accomplish this?

DR. GAUTHIER: My answer would be this, I know of one hospital whose building cost $1,300,000.00 especially for kitchens, renovating, renewing, cafeterias and residence and internes' quarters, the decision had to be made locally or taken locally and short term loans were made and financed. The building was started in an autonomous way like previously and later on half of it was recovered from the Minister of Health and the Province of Quebec.

COMMISSIONER BALTZAN: In other words, they were completely covered by the Hospital Diagnostic Services provided they were being paid for by the people?

THE CHAIRMAN: I think you are not understanding one another. The Hospitalization Act only refers to operating expenses and not capital costs.

COMMISSIONER BALTZAN: Thank you very much. What about the obtaining of the extra personnel that Dr. Laplante said? He has had shortages of various technicians, various areas are not completely the kind that require it, can you proceed on your own and obtain these services if they are available?

DR. LAPLANTE: If there is an increase of the principal, it was an increase in the equipment there, an increase in the salary we would have to put them in our budget and that would have to be approved before we could get it.

THE CHAIRMAN: I think that is the real question, what is the budgetary situation? Do you have to have the budget approved in advance or do you start again at the end of the year?

DR. LAPLANTE: We have to have our budget approved ahead of time.

THE CHAIRMAN: And if by reason of circumstances you exhaust that budget, what happens?

DR. LAPLANTE: We will find out shortly, the next year 1961 was the first year in the Province of Quebec and we are then going to extend representation showing the deficit.

THE CHAIRMAN: The program is not being completely worked out?

DR. LAPLANTE: Not yet.

COMMISSIONER BALTZAN: And if you have that deficit this year and you put in another budget for next year and other deficit, how do you plan to eventually catch up with your backlog?

THE CHAIRMAN: Without being facetious. We have just been told that the program, the formula has not yet been stated and, therefore, the judgment of these gentlemen on it is valuable personally but as a formula it is just a guess.

COMMISSIONER BALTZAN: I just wanted to see the local plan compared to others we have had.

THE CHAIRMAN: The Hospital Plan here has only been in force for a year, and, therefore, we cannot compare it with those places where the plan has been in operation a number of years and certain stresses and weaknesses have developed and either been faced up to or ignored.

COMMISSIONER BALTZAN: Thank you very much.

DR. LAPLANTE: We have to have our budget approved based of time.

THE CHAIRMAN: And if by reason of circumstances you exhaust that budget, what happens?

Dr. LAPLANTE: We will find out shortly, the next year like the first year in the Province of Quebec and we are then going to extend representation showing the deficit.

THE CHAIRMAN: The programme is not being completely worked out?

DR. LAPLANTE: Not yet.

COMMISSIONER BALTZAN: And if you have that deficit this year and you put in another budget for next year and other deficits, how do you plan to eventually catch up with your programme?

THE CHAIRMAN: Without being facetious, We have just been told that the programme, the formula has not yet been adopted and, therefore, the judgment of those gentlemen on it is valuable personally but is a formula to be proved, I guess.

COMMISSIONER BALTZAN: I just wanted to see the local plan compared to other we have had.

DR. LAPLANTE: In the terms for a year-end, therefore, in consult centre is with those places where the plan has been in operation a number of years and certain conferences and workshops have developed and either been faced up to or ignored.

COMMISSIONER BALTZAN: Then you are

THE CHAIRMAN: Dr. Firestone?

COMMISSIONER FIRESTONE: I have no questions.

THE CHAIRMAN: Thank you very much, gentlemen. We were very anxious to have the views of the hospital administrators in the matter of the work of the hospitals. We appreciate them in this province because the scheme has only been in operation for a short time and that you have not the historical background to rely on that other provinces have had. We will have to see how things work out in the future. We will be watching developments quite as interestedly as yourselves. Thank you.

THE CHAIRMAN: Mr. Hiscavitcz?

COMMISSIONER HIRSCHTICK: I have no questions.

THE CHAIRMAN: Thank you very much, gentlemen. We were very anxious to have the views of the hospital administrators in the matter of the work of the hospitals. We appreciate that in this province because the scheme has only been in operation for a short time and that you have not the historical background to rely on that other provinces have had. We will have to see how things work out in the future. We will be watching developments as intensively as yourselves. Thank you.

THE CHAIRMAN: Our next brief is that of the Province of Quebec Osteopathic Association and it will be known as Exhibit No. 229.

---EXHIBIT NO. 229: Submission of Province of Quebec Osteopathic Association.

S U B M I S S I O N O F

PROVINCE OF QUEBEC OSTEOPATHIC ASSOCIATION

APPEARANCES:

DR. B. E. MARSHALL

DR. D. A. PATRIQUIN

THE CHAIRMAN: Yes, Dr. Marshall?

DR. MARSHALL: Mr. Chairman and members of the Commission, Dr. David Patriquin, Vice-President for the Province of Quebec Osteopathic Association will speak for me.

DR. PATRIQUIN: Mr. Chairman, and members of the Royal Commission on Health Services, we have prepared, and will now give you, a summary of our brief.

Although the scope of osteopathic service has been severely curtailed by lack of adequate legislation the demand by the people for such service has exceeded the ability of the profession to provide.

Adequate legislation is necessary to allow osteopathic physicians to realize the full scope of their training in service to the Canadian people. Legislation establishing responsibility and rights is necessary to

[illegible] shall be known as Exhibit No. 229.

---EXHIBIT NO. 229: Submission of Province of [illegible]

S U B M I S S I O N O F

PROVINCE OF QUEBEC CONSUMERS CO-OPERATIVE ASSOCIATION

Introduction:

[illegible]

Dr. D. A. McKinnon

THE CHAIRMAN: Yes, Dr. McKinnon.

DR. MACKINNON: Mr. Chairman and members of the Commission, I'm David McKinnon, Vice-President for the Province of Quebec Consumers Association with speak for me.

MR. MARSHALL: Mr. Chairman, and members of the Royal Commission on Health Services, we have prepared, and we have got copies you, a summary of our brief.

Although the scope of consumerist service has been narrowed, mainly by lack of adequate legislation, the demand by the people for such service has grown, and the protection of provide.

Adequate legislation is necessary to allow consumerist movements to realize the full scope of their contribution to the Canadian people. Legislation must establishing responsibility and means is necessary

entice graduates of osteopathic colleges to locate in Canada. The Province of Quebec Osteopathic Association stands ready to assist, both in legislative matters and in the sponsoring of immigrating doctors of osteopathy to Quebec.

Greater utilization of osteopathic physicians may be gained through either the establishment of osteopathic hospitals or the opening of public-supported hospitals to osteopathic physicians and their patients.

It is pointed out in Paragraph 8 on page 3 of the brief that Detroit, Michigan, a city approximately the size of Montreal, has 347 osteopathic physicians. There are actually seven osteopathic hospitals in Detroit, Michigan, not four as stated in Paragraph 11 on page 4 of the brief. These seven hospitals have a total of 941 beds and 118 basinettes. This bed capacity, established mainly by private financing, has provided considerable additional health care facilities at minimum Federal and State cost. A similar growth of service could be encouraged in Quebec.

There are many rural communities in Quebec and throughout Canada that require health care. The special training of the osteopathic physician for rural general practice is noted in Paragraph 13, pages 4 and 5. In support of this statement some of the United States have a proportionately large share of rural health care provided by members of the osteopathic profession. A survey made by the Bingham Associates in 1956 entitled "The Unmet Needs in Medical Care of Rural People, State of Maine, 1956" showed that although the proportion of MD's to DO's was five to one in cities with a population of 5,000 or over,

[illegible] in overseas [illegible]
Canada. The Province of Quebec [illegible]
stands ready to assist, both in legislative [illegible] and in
the operation of immigrating doctors at [illegible], to
[illegible].

Greater utilization of [illegible] this
[illegible] may be gained through either the establishment
of overseas [illegible] or the opening of public-supported
[illegible] to [illegible] physicians and their families.

It is pointed out in Paragraph 8 on
page 5 of the brief that Detroit, Michigan, a city approxi-
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by members of the osteopathic profession. A survey made by
the Alumni Association in 1964 entitled "Osteopathic Medicine
in Rural Areas of Small People, State of Maine, 1964"
showed that a[illegible] the population of Maine's towns
[illegible] in cities with a population of 2,500 or over.

the proportion in towns of a population of 2,500 or under was three to one.

Increasing the number of osteopathic physicians in Quebec and Canada will help increase the number of doctors in rural areas and further help to alleviate the growing physician shortage.

Another means of providing adequate personnel is by the establishment of an osteopathic college or colleges in Canada. Federal and Provincial encouragement is sought in the establishment of both osteopathic colleges and teaching hospitals. And it is not necessarily so that we must have colleges before we have hospitals. Osteopathic teaching hospitals act as centres to attract graduates to an area

Because it is so vital we would, with your permission, like to read from the brief the Province of Quebec Osteopathic Association's stand regarding point of reference H. Point of reference H reads: "The methods of financing health care services as presently sponsored by management, labour, professional associations, insurance companies, or in any other manner".

" The Province of Quebec Osteopathic Association feels strongly that the method of financing health care services belongs to the individual citizen. If he prefers insurance as a fringe benefit of employment, from private insurance, personal funds, or if he prefers to pay the premiums through taxes, his will must be accomplished. In any event the patient should be guaranteed free choice of physician. By the same token, any program of health care for Canadian citizens should provide the

Increasing the number of occupational physicians in Quebec and Canada will help increase the number of doctors in rural areas and further help to [illegible]

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Because it is to which we would, with your permission, like to read from the brief the Province of Quebec Osteopaths Association's stand regarding point of reference B. Point of reference B reads: "The methods of financing health care services as presently sponsored by government, labour, professional associations, insurance companies, or in any other manner".

"The Province of Quebec Osteopaths Association [illegible] that the actual or financing means are residents belonging to the individual citizen, [illegible] from such as a fringe benefit of employment, [illegible] insurance, general funds, or if by payment [illegible] the provincial health [illegible]. We will [illegible] [illegible]. In our view the payment should be [illegible] from [illegible] of physicians. By the same token, any [illegible] of health care for another citizen should provide [illegible]

appropriate care that the patient requires, whether it be consultation with general practitioner, radiologist, surgeon, internist or other specialist."

Our recommendations are as follows:

1. More osteopathic physicians be encouraged to locate in Canada in general and in Quebec in particular, in order to improve the availability of osteopathic health care;
2. That public supported hospitals be encouraged to permit the patients of osteopathic physicians to remain under the care of the physician of their choice during necessary hospital experiences;
3. That the Royal Commission on Health Services encourage the establishment of an osteopathic hospital in Canada and the opening of opportunities for the training of osteopathic internes;
4. That the education and training of all categories of health care personnel be placed first on the priority list.

THE CHAIRMAN: Thank you very much. As a general question, in Quebec at the moment may an osteopathic physician admit to hospital? Has he that privilege?

DR. PATRIQUIN: No, he has not that privilege, because the osteopathic physician has no legal status as far as the statutes in this Province are concerned.

THE CHAIRMAN: None at all?

DR. PATRIQUIN: No.

THE CHAIRMAN: And why, do you know?

DR. PATRIQUIN: I do not know, sir.

"gown, internist or other specialist".

Our recommendations are as follows:

1. That orthopaedic departments be encouraged to foster research in general and in depth in particular, in order to improve the availability of orthopaedic care.

2. That public supported hospitals be encouraged to provide facilities of ambulatory operations to assist under the care of the physician of their choice.

3. That the Nova Commission on Health Services consider the advisability of an orthopaedic hospital in Canada and the providing of orthopaedic for the training of orthopaedic interns.

4. That the commission and trustees of all corporations of hospital care personnel be placed first on the priority list.

THE CHAIRMAN: Thank you very much, as a general question, in Quebec at the moment may an orthopaedic specialist work in hospital? Has he that privilege?

DR. MOFFETT: No, he has not that privilege, because the hospital privileges in Montreal are so few as the number of beds in hospitals are concerned.

THE CHAIRMAN: Does anyone

DR. MORRISON: No.

MR. MACDONALD: Actually, do you have

DR. MOFFETT: I do not know, sir

THE CHAIRMAN: You practise your profession as an osteopathic physician. Do you do that then completely outside the hospital area?

DR. MARSHALL: Yes, sir.

THE CHAIRMAN: Has there been any organized effort to have an osteopathic college in Canada?

DR. MARSHALL: There is an effort being made to form an osteopathic college in Canada at the present time. There are a group of doctors in Ontario who are sponsoring that effort, and they have made some definite plans for the establishment of such a college.

COMMISSIONER BALTZAN: Just one question, gentlemen. Who licenses osteopathic physicians to practise in the Province of Quebec?

DR. MARSHALL: There is no one licensing osteopathic physicians in the Provine of Quebec at the present time. We have letters from doctors who are here at the college, allowing us to practise osteopathy, use the title Doctor, and treat our patients according to osteopathic methods. We have to indicate on our plate outside the door that we are osteopathic physicians. The degree is Doctor of Osteopathy. At the present time there is nothing other than a letter which we receive from the President of the College of Physicians and Surgeons, April 1935.

COMMISSIONER BALTZAN: These letters are letters from older doctors of osteopathy at the College?

DR. MARSHALL: The letter I have is signed by the President of the College of Physicians and Surgeons of the Province of Quebec.

[illegible]

[illegible]

[illegible]

THE CHAIRMAN: Thank you, gentlemen. Your brief and the supplementary brief received this morning will have our consideration in due course.

We will now rise until two o'clock.

---Luncheon Recess.

THE CHAIRMAN: We will proceed now with the Royal Victoria Hospital. Dr. Turner, you are here on the invitation of the Commission to give us certain information about some practical aspects of the working of the Hospital Diagnostic Service Act in relation to the Royal Victoria Hospital.

---EXHIBIT NO. 229: Submission of the Royal Victoria Hospital.

APPEARANCES:

DR. J. GILBERT TURNER

DR. TURNER: Thank you, sir. I have prepared a memorandum and I have presented copies to the Secretary. Perhaps if I could read it:

In response to your invitation of March 12th, I have the honour to present herewith some statistics for the calendar year 1961 with regard to patient care in the Royal Victoria Hospital and, in some instances, their comparison with 1960, together with certain comments.

As the Quebec Hospital Insurance Service became operative on January 1, 1961, under the provisions of Federal Bill 320 and Provincial Bill 2, these statistics of the last year under the previous system and of the first year under the new are of special interest.

The Royal Victoria Hospital is a public general hospital, incorporated by the Senate and the House of Commons of Ottawa in 1887. It has now 1018 beds and is

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As the Canada Hospital Insurance Service became operative on January 1, 1961, under the provisions of Federal Bill 320 and Provincial Bill 5, these statistics of the last year under the previous system and of the first year under the new are of special interest.

The Royal Victoria Hospital is a public general hospital, incorporated by the Senate and the House of Commons of Ottawa in 1887. It has now 615 beds and is

governed by a Board of Governors numbering fourteen, of whom eight are elected and six are ex-officio. We receive all types of patients, except those with communicable disease. The total cost of operation in 1961 was just over $11,000,000.

Our first duty is to the patient but we have very heavy responsibilities to teaching and to research.

We are one of the two main teaching hospitals of McGill University for undergraduate medical students. We have also some 260 young post-graduate doctors as interns, residents and Fellows. Our three-year diploma School of Nursing has an enrolment of 345 and there are 49 post-graduate and affiliate students in nursing. More than 400 young ladies since 1927 have served as dietetic interns at the Royal Victoria. Physiotherapy students and Social Service students obtain part of their practical training with us. In Hospital Administration, seven university graduates have served their residency under the Executive Director.

We believe that the best in patient care is not possible without teaching and research. In the Royal Victoria, research is financed by non-hospital funds, both as to staff and equipment. The Hospital provides the physical facilities and housekeeping and maintenance services. In 1961, funds given directly to the Hospital specifically for research amounted to $375,000; much more came to the various departments through the corresponding University department.

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Our third duty is to the patient but we have very heavy responsibilities to teaching and to research.

We are one of the two main teaching hospitals of McGill University for undergraduate medical students. We have also some 300 young post-graduate doctors as interns, residents and fellows. Our three-year diploma School of Nursing has an enrolment of 90; we have there are 19 post-graduate and affiliate students in nursing. More than 400 young ladies since 1947 have arrived as

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Some statistics for the calendar year 1961, and related to 1960, are as follows:

1. Admissions were 22,295, an increase of 7%, with with 66% from Montreal and 28% from the rest of the Province.

2. The waiting list for admissions has doubled and now runs about 1100.

3. Days of patient care increased 15%.

4. 42% of our patient days were standard ward.

5. Average days' stay per patient increased 9.8% from 12.2 days to 13.4.

6. Average daily occupany was 86.3%, an increase of 4.5%.

7. X-ray examinations increased 25%.

8. Laboratory examinations increased 18%.

9. Physiotherapy treatments increased 25%.

These increases in examinations and treatments (items 7, 8, and 9 above) are above the 7% increase in in-patient admissions, and the 14% increase in out-patient visits. We do not have the statistical breakdown of the actual increases as between in-patient and out-patient services, but the figures given would indicate an increase of the average service load rendered to the individual patient.

We are confronted with two major problems: (1) The increased demand for admission as in-patients, as evidenced by the 100% increase in our waiting list; a check with our admitting office two days ago showed the waiting period for non-emergency cases to be 14 days for standard ward, 18-23 days for semi-private (medical and surgical) and 14 days for private patients, that was the picture as of yesterday and it may go only for

one. This is not a guarantee date. And (2) the increased demand upon our radiological and laboratory services for ambulatory care.

Naturally, in assembling these statistics we were interested as to whether we were out of line with other hospitals in the City. A spot check was made and we can say in general that we found our statistics in keeping with a common trend.

With regard to the point of unused beds, we have no beds closed because of staff shortages. Understandably the picture may well change in the Summer months.

Within the past two days I personally in company with the Chief Resident and Head Nurse made a survey of a certain number of our wards. The first column is the number of patients actually in the ward and the needs of the patient, medicine, surgery and so forth with keys for my own identification. Of the 195 patients that we surveyed on seven floors, the Resident and I went over every patient and he explained why they were in, why they could go to convalescent. In summary 141 of these 195 patients, only 141 were actually in need of such services, 73.2%. It is rather interesting, in the second line, 35 medicine 8, 12 were considered candidates for convalescent, and the other large figure in the convalescent was our traumatic ward. These were the figures as of yesterday and the day before. They might quite possibly vary two weeks from now or two days from now. I think they are very suggestive, indicate a very definite trend. The remaining 54 or 27.7% could be cared for in adequate alternative facilities. I pointed out to our Resident, for

demand upon our radiological and laboratory services for

[illegible]

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[illegible]

With regard to the policy of turned back we have no beds closed because of staff shortages. Under already the pictures may well change in the Summer months.

Within the past two days I personally in company with the Senior Resident and Head Nurse made a survey of a certain number of our wards. The first column is the number of patients actually in the ward and the needs of the patients, medicine, surgery and so forth with from my own identification. Of the 129 patients that we surveyed on seven floors, the Resident and I went over every patient and he explained why they were in, why they could go to convalescence. In summary 141 of these 129 patients, only 18 were actually in need of such services (12.6%). It is rather interesting, on the second floor, 39 patients. 31 were found to be ambulatory for convalescence, and the other seven were in the convalescent [illegible] stage. These were the figures as of [illegible] the day before. Now might quite possibly vary [illegible] from day to day from now. I think that is [illegible] very important. In our own hospital we have [illegible] averaging 94 or 17 [illegible] active treatment. I [illegible] out to our [illegible]

instance, in the convalescent hospitals we would expect graduate nursing care, full-time medical care. There should be adequate physiotherapy available in the chronic hospital. They should be prepared to change dressings and do physiotherapy and you might expect to look after bed-ridden patients in the rehabilitation, of course, or where they would have the full facilities for retraining of very much injured hands or an amputee. You will note it is in the last category, under ambulatory, there was a slight difference in opinion between the Resident and what his chief thought as to whether this patient could be looked after outside, and being the Resident he had to abide by his staff man.

Spot checks within the past two days on representative medical and surgical wards revealed that the patient census could be reduced in the following manner if adequate, I emphasize adequate, alternative facilities and services were available. (Those for discharge April 14th, 15th, and 16th are excluded.)

		Could be transferred to:				
Patient Census	In need of acute hospital care	Convalescent	Chronic	Rehabilitation	Custodial	Ambulatory
27-Med 7	18	5	4	-	-	-
35-Med 8	23	12	-	-	-	-
20-Surg 8E	16	4	-	-	-	-
30-Surg 7W	24	1	3	-	-	2
30-Surg 9-0	25	4	1	-	-	-
31-Surg 9-T	16	13	-	2	-	-
22-Surg D	19	2	-	-	-	1
195	141	41	8	2	0	3

In summary, of the 195 patients on acute general wards, only 141 or 72.3% were actually in need of such services and facilities. The remaining 54, or 27.7%, could be cared for in adequate alternative facilities.

The effective and efficient use of hospital facilities, beds, operating rooms and diagnostic services is a very complex problem.

Certainly, it is reasonable to proceed on the premise that the acute general hospital should be reserved for those patients who need its services. The statistics just quoted emphasize very clearly that this principle is not followed in practice, and we naturally ask why. The answer is that adequate alternative facilities are not available. I would advocate, as a matter of fact I already have, an immediate survey by the appropriate governmental authority of this Province as to the existing facilities, and the immediate and long-range requirements for modern and well-staffed accommodation for the

In summary, of the 193 patients in some general wards, only 141 or 72.5% were actually in need of such services and facilities. The remaining 54, or 27.7%, could be cared for in <u>adequate</u> alternative facilities.

The effective and efficient use of services is a very complex problem.

Certainly, it is reasonable to proceed on the assumption that the scarce venereal hospitals should be reserved for those patients who need the services. The publication just quoted emphasizes very clearly that this principle is not followed in practice, and we naturally see why. The reason is that <u>adequate</u> alternative facilities are not available. I would advocate, as a result of what I mention here, an immediate survey by the appropriate governmental authority of this problem as to the existing facilities, and the immediate and long-range requirements for modern and well-staffed accommodation for the

convalescent, the long-term illness and custodial care.

I would go further and suggest that the fullest consideration be given to this urgent need of alternative facilities before any extensive programme is undertaken for additional acute general beds.

Operating rooms are expensive in construction, in equipment, in staffing and in the silent hours of non-use. One might ask if the operating rooms could be used to greater advantage for elective surgery during the entire day. Without going into all the factors, I think it would be possible, provided that staffing could be arranged, for operating rooms to be used more effectively during the day hours than they are now. I would like to add here our operating rooms are used on most of Saturdays and very often in what we call the silent hours on Sunday they are busy with emergencies, but not to the fullest use one has in mind. A time-study would be necessary to reveal the actual effective use of operating rooms, both present and potential.

With regard to diagnostic facilities, our experience in the significant increase in radiological and laboratory examinations in 1961 over 1960, and still not levelled off, poses a real problem. It would seem reasonable to assume that part of this increase is due to the removal of the direct financial responsibility of the in-patient, they are the only services covered, to pay for these services. Prescription of diagnostic procedures is solely the prerogative of the attending physician. In addition to the essential laboratory examinations there are those which could be classed as desirable. The administration

I would be [illegible] to see an open [illegible]

[illegible] should be given to this [illegible] of

[illegible] that [illegible] are [illegible] particular

[illegible] in [illegible] and [illegible] General [illegible].

Operating rooms are [illegible] in [illegible]

[illegible], in [illegible], in [illegible] and in the [illegible]

[illegible] of [illegible]. The [illegible] of the [illegible]

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add here our operating rooms are [illegible] on [illegible] of [illegible]

and very [illegible] in which we call the [illegible] house on [illegible]

they are [illegible] emergencies, but not to the [illegible] [illegible]

one [illegible] it [illegible]. A [illegible] would be necessary to [illegible]

the [illegible] effective use of operating rooms [illegible] [illegible]

and [illegible].

[illegible] to [illegible]

[illegible] not [illegible], [illegible] a [illegible] problem. It would [illegible]

[illegible] to [illegible] [illegible] of the [illegible] [illegible]

[illegible] [illegible]. We [illegible] financial [illegible] [illegible]

[illegible]. [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible]. [illegible] of [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible].

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

[illegible] which [illegible] [illegible] [illegible] [illegible]. The [illegible]

should render every assistance to the medical staff in their efforts to keep desirable examinations to a minimum.

Naturally, this sizable increase in demand has placed an almost impossible work load on our laboratory staff, which has already been increased by a modest number of personnel but not in direct proportion to the increased work load. The full increase has not been possible because of space limitations and budget restrictions.

It must be appreciated that the extension of Hospital Insurance benefits to out-patient services will aggravate an already severe problem, at least in our own Hospital, with regard to radiological and laboratory space and staff, and this means new construction which, understandably, cannot be accomplished in the immediate future.

It is an honour, Mr. Chairman and Members, to be invited to appear before you and I trust that this short presentation may be of some small assistance in your deliberations.

THE CHAIRMAN: I want to thank you, Dr. Turner, for your response to our invitation and for going to the trouble that you and your staff has to to give us the analysis which we find in the written submission. You do mention this matter about patients, possible out-patients extension which you say is going to give a considerable amount of difficulty.

DR. TURNER: It is, sir, and I think it is fair to say, because I am speaking for my own hospital, at a meeting in December of some sixty-three

[illegible] y consideration to the medical staff in [illegible] r efforts to keep desirable examinations to a minimum.

demand has placed an almost impossible work load on our laboratory staff, which has already been increased by a sufficient number of persons but not in correct proportion to the increased work load. The full increase has not been possible because of space limitations and budget restrictions.

It must be appreciated that the extension of hospital insurance benefits to out-patient services will increase an already severe problem, at least in our Hospital, with regard to radiological and laboratory space and staff, and this means new construction [illegible]

[illegible]

Thank you very much, Dr. Chalmers [illegible]

[illegible]

THE CHAIRMAN: I think [illegible]

Dr. Turner, [illegible] response to the [illegible] ing to the [illegible] you and [illegible] the analysis which we [illegible] in the [illegible] to [illegible] matter [illegible]

[illegible] considerable amount [illegible]

DR. TURNER: [illegible]

[illegible]

hospitals from various parts of the Province I was rather surprised a great many didn't share my concern. In other words, they felt they could handle it. Speaking from the point of view of the Royal Victoria we would be very hard pushed, as a matter of fact would have to have more facilities and staff.

THE CHAIRMAN: I suppose it is fair to assume a metropolitan hospital would find the out-patient population far more serious, far greater proportionately than the hospitals in any of the smaller communities, even though they are sizable.

DR. TURNER: Correct, sir.

THE CHAIRMAN: Assuming the need for increased facilities, would these facilities not be justified, would they be justified in relieving the hospital of any patient, of the demands now need that might be taken care of in the out-patient department?

DR. TURNER: I was impressed Saturday and Sunday in going over, I actually walked around the wards myself, not all of them, but most of them and when we came around the Resident said that this man was in for investigation and I said "What kind of investigation?" It was a very complicated case. I think if times were really rough and we had to clear the beds out we could do that, but if the patient's complex tests had to be done I think they were justified. Getting back to your question, I am not so sure that in our own case the institution of an out-patient service would relieve the number of beds; some might think they would judging by the type of patient we have now.

THE CHAIRMAN: It is on the judgment of such men as yourself that we have to rely very heavily, because these statements are made sometimes by persons with knowledge and sometimes by persons without knowledge or perhaps not much knowledge in the relative field.

DR. TURNER: I would think that maybe it would be a small saving, but I do not think it is of the magnitude some would have us believe. I think it is supported by spot checks periodically but certainly in my impression for the last few days which is a normal average in the life of our hospital.

THE CHAIRMAN: Have you any type of home care program emanating from Royal Victoria and do you visualize such a program might be of assistance in shortening the hospital stay of certain patients?

DR. TURNER: We do not have a home care program. We have, however, a resident V.O.N. nurse who does an excellent job of liaison between the staff and the home. It does not fulfill the purpose of home care, but it is a step. I think from my knowledge of home care that one again has to proceed on the basis that there is a very small percentage of the actual hospital population that are amenable to home care. I think probably it is an adjunct and those who have it certainly think it is wonderful, but, again, I think it has to be placed in its proper perspective with the other services.

COMMISSIONER GIRARD: Mr. Chairman, I do not think I have any questions except to ask for some clarification of this. You gave here data on 195 patients, but you have 1,000 in the hospital; was this data covered

THE CHAIRMAN: It is on the basis of such men as, I assume, that we have to rely very heavily, because these estimates are made corrections by persons with knowledge and sensitiveness by persons without knowledge or perhaps not such knowledge in the receptive field.

DR. TURNER: I would think that maybe it would be a good evening, but I do not think it is of the magnitude some would have us believe. I think it is supported by good clinical psychology but certainly in my impression for the last two days which is a normal sample in the life of our hospital.

DR. GOLDMAN: Have you ever been at home care programs coming from Rural Veterans and do you visualize such a program ever satisfactorily functioning the hospital staff of clinicians?

DR. TURNER: We do not have a home care program or clinical job of liaison between the staff and the home. It does not fulfill the purpose as home care, but is not a study. I think from my knowledge of home care there are reports that is proceed on the basis that there is a very small percentage of the actual hospital population that are amenable to home care. I think probably it is an ad hoc and there is to have to secondary which is essentially, and again, I think it has to be geared in the proper perspective with the other services.

CHAIRMAN: The question is, Mr. Chairman, do you think I have my conclusions stated in a fair manner or not then, I guess that is the question: you have given me

through your ward and semi-private patients only or just the ward patients?

DR. TURNER: The first two medically were about 50/50 standard ward and semi-private; the last one was all public and on the other four wards I think there would be probably 75, but there would be compensation and standard ward. We have 200 beds in our maternity and those were excluded; we had 100 beds in psychiatry and they were excluded. I excluded our private wing and I did not have time to do neurology or otolarnychology and so forth, but this would represent the patients except private.

COMMISSIONER GIRARD: You said 72% of the people there really had to be there, so if you had covered the private patient wards and some of the others, would you think it would have been the same as this?

DR. TURNER: No, I think it would probably have been -- it would not have been quite so impressive. You take 200 out of the maternity which you cannot do anything about.

COMMISSIONER GIRARD: What about private rooms?

COMMISSIONER McCUTCHEON: That might be more impressive.

DR. TURNER: I was going to say that if I had done that it probably would have increased the figure that did not need to be there.

COMMISSIONER GIRARD: That's what I thought.

COMMISSIONER VAN WART: Your figures, fourteen days was your average stay for your private patient,

MR. WYNNE: Are there two [illegible],

[illegible] 300/350 [illegible] and [illegible] the [illegible]

one was [illegible] on the [illegible] [illegible]

there would be probably [illegible] more [illegible] [illegible]

and [illegible] wood. We have 800 beds in [illegible] [illegible]

those were [illegible] and 100 beds in [illegible] and

they were on [illegible]. I [illegible] [illegible] [illegible] and I do

not have time to [illegible] [illegible] [illegible]

COMMISSIONER [illegible]: [illegible] 75% of

the people there [illegible] to be there, so if you had

converted the private [illegible] and [illegible] [illegible]

would you think it would have been [illegible] to [illegible]?

MR. TURNER: No, I think it would

probably have been -- it would not have been [illegible]

[illegible]. You take 800 out of the [illegible] [illegible]

cannot do anything [illegible].

COMMISSIONER [illegible]: [illegible]

[illegible]?

[illegible]

more [illegible].

I. [illegible]: [illegible]

I had [illegible] [illegible] [illegible]

[illegible] be [illegible].

COMMISSIONER [illegible]: [illegible]

[illegible]

[illegible] [illegible]

was it not? You mentioned that?

DR. TURNER: 13.4 for all patients.

COMMISSIONER VAN WART: But for the private?

DR. TURNER: That was all patients, all categories and all types.

COMMISSIONER VAN WART: But you broke down some private and semi-private in your brief?

DR. TURNER: No, I did not. On page 2 where the average days' stay increase was 12.2 to 13.4, that is the total increase for the thousand beds for the year. And now, I have the figures here, but it would take some time to bring them out as to the length of stay on the private side and semi-private and public. I think there is very little difference between semi-private and public.

COMMISSIONER BALTZAN: I will just take up one matter -- it is too bad we have not had a chance to digest the whole thing. Would you care to take care of the matter of diagnostic facilities? That is the only part of the total diagnostic problems presented by the patient, actually you are speaking there in terms of diagnostic aids in the diagnosis and so that there must, in addition to that, be for the final diagnosis the people who come up there?

DR. TURNER: That is right, sir.

COMMISSIONER BALTZAN: So it cannot be conceived that because these people have this opportunity to come in and get this diagnostic service that they are getting the diagnosis?

DR. TURNER: Is it for all patients?

MRS. SOLOMON VAN WERT: Not for the

[illegible]

DR. TURNER: That was all patients,

all categories of our cases.

COMMISSIONER VAN WERT: Isn't you have

some sort private and semi-private in your hospital?

[illegible]

where the average daily increase was 4.2 to 1,[illegible]

that is the total increase for the nursing beds for one

year. And now, I have the figures here, but it would take

some time to bring them out as to the [illegible] or [illegible] on

the private side and semi private one point. I think

there is very little difference between semi and [illegible]

COMMISSIONER MURZAKI: I will [illegible]

in one matter -- it is too bad we have not [illegible]

about the whole thing. Would you care to take care of

either of diagnostic facilities? That is for only [illegible] of

the total [illegible] problems presented by the patient,

actually you are speaking there in terms of diagnostic

also in the diagnosis you do take there [illegible]

to that, be for the final diagnosis for people who come

in there?

DR. TURNER: That is [illegible]

COMMISSIONER MURZAKI: So it seems to

[illegible] that because these people have [illegible]

to come in and get into diagnostic [illegible] that they are

[illegible] for diagnosis

DR. TURNER: Very true.

COMMISSIONER BALTZAN: Only getting the benefit of diagnostic aids. You state that you do not think your hospital bed requirements would be lessened even though you installed your out-patient service?

DR. TURNER: That is right.

COMMISSIONER BALTZAN: And you do not think the tests would be lessened because you are a teaching and research institution?

THE CHAIRMAN: There was some suggestion that the days would be lessened, the number of patients could not get into a hospital and they would be fewer, that was the only point put to the doctor and he said he doubted if there would be any noticeable change.

COMMISSIONER BALTZAN: But in the general run of the procedure connected with diagnosis you mentioned certain types of patients that are borderline, that they may not be considered acute, but in order to arrive at the diagnosis it is important to stay in the hospital those who may be short of breath.

DR. TURNER: Because of the complexity of diagnosis.

COMMISSIONER BALTZAN: A period of observation to make the diagnosis?

DR. TURNER: That is right.

COMMISSIONER BALTZAN: Thank you very much.

COMMISSIONER FIRESTONE: On page 2 you say that the waiting list for admission has doubled and runs about 1100. How long does the average patient have to

wait until he may be admitted to the hospital, emergencies excepted?

DR. TURNER: I think the figures are on the top of the next page. It runs from 14 days to 23 days. As of the moment it is rather of interest, in the past year 40% of our medical admissions and the emergencies, when it is a very real thing that a person may be booked today for ten days from now, but a week from now will develop into an emergency so these days are not guaranteed.

COMMISSIONER FIRESTONE: You are saying on page 2 that the waiting list has doubled, has the waiting period also doubled?

DR. TURNER: No, I do not think it has. In some cases it is very definitely lengthening and also it depends on what disease a person happens to have at that moment, whether there may be beds on one side or not in another or one service and not in another.

COMMISSIONER FIRESTONE: If there were facilities available to take care of the 54 patients that could be transferred, as you mention on page 3, if such facilities became available, what would this do to your waiting list and the waiting period?

DR. TURNER: It would shorten both and make a tremendous amount of people much happier. If you take these people out you are going to place a very heavy nursing load on the people because all the people are going to be very sick and it would mean whole reorientation of our nursing service to the point of view of putting patients in an eight-bed ward or twelve-bed ward. This is a very real point.

COMMISSIONER FIRESTONE: On page 5 you say in the second paragraph that the increase has not been possible because of space limitations and budget restrictions, what budget restrictions do you have in mind?

DR. TURNER: Provincial, under the Quebec Hospital Insurance.

COMMISSIONER FIRESTONE: Can you just explain to us that if there is demand for services and you need more staff to run those services why should you not be able to obtain the staff to run these services, because otherwise you have to reduce these services if you have not got the people to do the job.

DR. TURNER: May I say this is a burning question in the Province now. We have put in our budgets, we have not had a final word for 1961, we have not heard of our 1962. Sometimes it is a little hard for someone a few miles away to understand the urgency of the day to day situation. I will say that in Quebec and I think it is true in any hospital, that is the need is there, it has to be done as we have done for seventy years, do our job and expect to be reimbursed for it.

COMMISSIONER FIRESTONE: Thank you very much.

COMMISSIONER McCUTCHEON: Have you any guarantee you are going to be reimbursed?

DR. TURNER: I would not put it in writing.

COMMISSIONER McCUTCHEON: In other words, you are now in a position where you are competing with demand for new roads, new toll bridges, pretty well everything?

DR. TURNER: That is right, sir, we have to plead our case and if we plead it well enough we will get it, and we hope to plead it well.

COMMISSIONER McCUTCHEON: But up to date you are still in the position you described?

DR. TURNER: Yes, and there will be more pleas coming forward, I suspect.

COMMISSIONER BALTZAN: At the moment you are doing some definite budgeting?

DR. TURNER: Yes, we have already had our annual meeting and we figure the deficiency between the payment of what we could have been paid was $700,000.00.

COMMISSIONER VAN WART: You mention the chronic patients in your hospital and you also in your brief suggest that chronic care hospitals be given preference over expansion and construction of acute hospitals. I was wondering what your ideas might be having a chronic section constructed in connection with the acute hospital. I would see certain advantages in certain services which would be available to you and would allow you freedom of movement with your patients and so on, and in the long run I can see it would not be as expensive as constructing a new hospital.

DR. TURNER: There is no question that a facility for the chronically ill in a separate building on the same grounds of a hospital would be infinitely better from the point of view of the patient, because he is then assured of continuity of care by people who are able to understand. Your own staff can go in rotation to see him and you can rotate your resident staff. You would

have the same quality of nursing care and I think your point is very well taken because I certainly would not want to leave the impression that I would advocate the building of such a building five miles away. I am sure members of our attending staff would favour your suggestion of being on the same grounds, geographical juxtaposition.

THE CHAIRMAN: Thank you again, we are obliged to you and grateful to you for having come.

THE CHAIRMAN: The next brief will be that of the Montreal General Hospital.

S U B M I S S I O N O F

THE MONTREAL GENERAL HOSPITAL

APPEARANCES:

MR. A. H. WESTBURY

DR. W. STORRAR

MR. WESTBURY: I have a submission I would like to make. I will speak in general terms and Dr. Storrar, our Medical Director of the Montreal General Hospital, will speak in specific terms, as the situation affects the Montreal General Hospital.

In his letter of March 12th, 1962, inviting an appearance before the Royal Commission, the Chairman, Judge Emmet Hall, stated that the Commission would be interested in our views concerning the availability of chronic and convalescent beds in Quebec, and, in particular, the effect that the inadequate number of such beds has on the general operation of the Montreal General Hospital.

According to Tables of "Distribution of Hospital Beds" included in the Canadian Hospital Directory, 1961, there are 16,481 chronic and convalescent beds available for patients using the 88,325 active general beds operated by hospitals (other than Federal) across Canada; a ratio of approximately 2:11. The ratio in Ontario is 2:9 and in Quebec 2:8. On the face it would appear that Quebec is better off than either Ontario or the rest of Canada, but an analysis of the 5,504 chronic and convalescent beds

available in this Province shows that 3,512 (or 63%) are operated by religious orders compared with 26% for Ontario and 35% for Canada. Religion and language are very important factors which must be taken into account by general hospitals in this province when arranging chronic or convalescent care for their patients.

Of the 1,992 chronic and convalescent beds in Quebec operated by non-religious groups 546 (or 27%) are located in private hospitals, and the patient's inability to pay for private care over and above any payment made by the Hospital Insurance Service is also a deterrent in the placement of patients requiring long-term care.

The situation is aggravated by the necessity of some long-term hospitals which because of inadequate facilities or insufficient trained personnel have to adopt a selective policy in accepting patients. Some will not take terminal cases; others will take only those cases requiring a minimum of nursing care and a number prefer ambulatory patients who, to some extent, can look after themselves.

It is interesting to note that from April 1948 to March 31st, 1961, chronic and convalescent beds approved for assistance under the Hospital Construction Grants numbered 9,214 compared with 55,068 active treatment beds. (vide National Health Grants 1948-1961, Dept. of National Health and Welfare - January 1962) a ratio of approximately 1:6.

It is stated in page 40 of this Report that:

"One of the objectives of this grant was to encourage the construction of additional accommodation for chronic and convalescent patients so as to improve their care and release acute hospital facilities. It was envisaged that they could be accommodated in specially-designed hospitals or in wings attached to acute treatment hospitals with potential savings in nursing and other costs.

With the advent of hospital insurance, officials concerned with stabilizing costs realized as never before that the cost of extended care needed for many patients in acute treatment hospitals could be reduced and more effective care be given to these patients if special units were provided for them. Also with an aging population often prone to long-term illnesses, the need would be accentuated. At present hospital accommodation for the care of chronic diseases is receiving priority in most provinces."

Again in dealing with the current situation, the Report states:

"During the past eight years considerable progress has been made by the provinces in the multiplication and expansion of facilities and resources for medical rehabilitation and chronic care due to the availability and utilization of financial support under the National Health Program. However, if we want to describe accurately the present organization of local services, we have to admit that comprehensive assessment and restorative programs directed against disability and chronic disease are still far from being adequate to meet the present health needs of Canada. Many factors are together responsible for such

a situation; and too frequently still the prevention or limitation of disability and of chronic invalidism in the routine medical management of acute disease or injury is not accomplished because adequate facilities are not readily available at the appropriate time and place. Many institutions to which sick people are admitted for active treatment of their short-term or long-term illness are still operating without the resources in personnel, space and equipment adequate to combat effectively the crippling after-effects of disease or injury. The restorative value of such programs as out-patient and home care, by contrast with the more frequently disabling influence of a prolonged stay in an institution, is not yet sufficiently understood or commonly available."

It is apparent that the placement and rehabilitation of chronic cases has been a problem for some time. Notwithstanding that with financial assistance from both Dominion and Provincial Governments additional facilities for long-term cases have been provided, the accommodation for chronic cases in the Province of Quebec is still wholly inadequate to meet the demand. The situation has been accentuated since the advent of Hospital Insurance in Quebec and the resulting pressures on general hospitals by the Hospital Insurance Service to keep the average stay of patients to a minimum.

The solution, of course, is the provision of more chronic hospitals and expanded facilities for medical rehabilitation. But it takes time to build hospitals and the situation calls for some immediate remedy. One method is substantially increased financial

assistance for Home Care Programs to be administered by the general hospitals. A large proportion of chronic patients could return to their homes if they are assured that nursing care and medical attention will be available as and when required. Some 5 to 6 years ago The Montreal General developed a Home Care Program (of which Dr. Storrar will speak in greater detail) but it was never put into operation because our application for a Dominion-Provincial Grant was refused on the grounds that a pilot study was already under way at the Reddy Memorial Hospital. Assistance for this study was discontinued after two years and has since operated on a limited basis and financed by the Hospital from its own resources. The Program initiated by the Montefiore Hospital and the New York Hospital has demonstrated quite clearly that Home Care for the chronically ill is both feasible and practical and in the absence of sufficient hospital beds and facilities for taking care of long-term cases it would appear that Home Care programs operated by general hospitals should be encouraged and supported to a greater extent than is the case at the present time.

THE CHAIRMAN: Thank you very much, Mr. Westbury.

MR. WESTBURY: May I, with your permission, sir, ask Dr. Storrar if he would speak on certain matters specific to the Montreal General Hospital?

THE CHAIRMAN: Yes.

DR. STORRAR: I have looked over the weekend on the statistics for the past year, and our figures as they stand as to this past weekend.

During the past year we have received requests for members of our attending staff for placement in chronic hospitals or convalescent hospitals for a total of over 1500 patients. We have been able to place only 50%. 356 patients were actually placed in long-stay chronic hospitals. 359 were placed in convalescent hospitals, which is a little over 50%. As to this weekend we had 32 patients out of a total of 730 beds, 32 patients, a whole nursing unit approximately, with patients awaiting placement for long-stay or convalescent beds. In other words, these beds were blocked as far as the admission of acute patients was concerned. I also had a poll taken of four convalescent or chronic hospitals in the city, and 22 nursing homes. These being hospitals and nursing homes that we commonly use for the placement of chronic and convalescent patients, and there were available, unoccupied and staffed, only 39 beds out of a total of 900 beds. Now, you may well ask, Mr. President, we have 32 patients to be placed and there are 39 beds available to place these patients, why cannot we place them? They are cases of terminal cancer, senile arterial sclerotic management problems, patients of over 65, patients who require rehabilitation facilities, patients who require tube feeding to be carried out by a nurse, and these beds that are available, the hospitals or nursing homes will not accept such patients, and therefore they have to remain with us until we can find a nursing home or a hospital that will take this type of patient.

I feel that, apart from the fact that we do need many more beds to place these patients, that

some affiliation between an acute hospital and a chronic hospital or convalescent hospital would be of some value, but particularly with a common medical staff and a common social service staff.

Also a home care program, I feel, would help in many instances, especially if such a home care program was run under the direction of the acute hospital. Furthermore, a central placement bureau might be of some value. Our social service department will spend hours ringing up hospitals and nursing homes to try and get one specific patient placed. We never have any up-to-date information, day to day information, on the number of beds that are available, and I feel that a central placement bureau would be of some value.

To return to home care program, I feel that such a program should bring in various community services, public health nurse, the social worker, the diet centre, and also the attending physician in the acute hospital. I also feel, and I talk here as Director of a teaching hospital, that it would be beneficial to our residents and internes, and to medical students, to be affiliated with such a program and undertake such work, which would be useful when they go out into practice.

THE CHAIRMAN: Thank you very much, Doctor.

COMMISSIONER BALTZAN: Just one question, Dr. Storrar, please. You stated I think your medical staff has requested the removal of something like 1500 patients during the past year?

DR. STORRAR: That is correct.

COMMISSIONER BALTZAN: It was on their initiative seeing that they could be taken care of elsewhere?

DR. STORRAR: That is right.

COMMISSIONER BALTZAN: My question to you, sir, is this. Has the converse happened, where medical staff may have admitted patients that do not need the full hospital care, or taking advantage of the current situation and giving patients this accommodation, not strictly needing it?

DR. STORRAR: You are referring particularly to cases for investigation, would I take it that this is what you are referring to?

COMMISSIONER BALTZAN: Well, I think I could excuse that. I am thinking about taking advantage of the hospitalization, that patients are now being given the advantage of being hospitalized that could perhaps be kept out of hospital, at home, or say on an out-patient service basis?

DR. STORRAR: This may happen occasionally, but as Medical Director of the Montreal General it is one of my duties to screen all such admissions, and in fact the admission of all patients is directly my responsibility and there is no other administrative person superimposed between myself. I work directly with the staff. I will admit that it is possible as far as investigation is concerned, this is the type of case that I do look into very frequently as the Director of the staff of a teaching hospital mostly dealing with referred cases, I do feel that the patients who come in for investigation to the Montreal General are normally the type that really do require

admission, if I get your question correctly?

COMMISSIONER BALTZAN: You have, and you have given the answer, and may I add to that that insofar as your personal experiences are concerned there are no overt abuses of that?

DR. STORRAR: I don't feel there are.

THE CHAIRMAN: Not when you can get your eye on them, Doctor.

DR. STORRAR: No, that is right.

COMMISSIONER GIRARD: Dr. Storrar, Mr. Westbury said a few minutes ago that some five or six years ago the Montreal General developed a home care program and asked for a Provincial-Dominion Grant but was refused on the grounds that a pilot study was already underway in the Reddy Memorial Hospital. Has this request been put before the Provincial Government once more in recent years?

DR. STORRAR: No.

COMMISSIONER GIRARD: Well, I happen to know that as late as two or three months ago I think one such program was started in a hospital in Montreal, and I heard recently that a second one was starting, so I wonder if these hospitals are starting programs why you wouldn't be able to get the money to start one too?

MR. WESTBURY: Well, yes and thank you for that information, Miss Girard. We will certainly put in another application and see what happens, then we are at the present time going to see some very generous assistance from the Provincial Government in regard to our proposed building program, and we are not quite certain exactly whether they would be prepared to match any other

grant for another project. I don't know, we will try.

DR. STORRAR: I wonder if a program such as ours, it would be in a fairly large scale in that we have a very large out-patient department, and many patients of course requiring placement. It may be that such a program would be too expensive. However, I think if other hospitals are doing this, I think we should try again.

COMMISSIONER GIRARD: Was this asked as a pilot project, because it is my impression that we are beyond the pilot project stage in home care. I think this has been demonstrated to most of the people's satisfaction, that home care is efficient and will do some of the things we want it to do, so should we be asking for money for pilot projects for home care, or should we be asking for the facilities to develop home care, and not talk about pilot projects any more?

MR. WESTBURY: No, we didn't ask for it on the basis of a pilot study. That was the grounds on which it was refused. The purpose of my statement was not specifically so far as the general hospital is concerned, but a general statement that home care programs across the country be operated by general hospitals in our opinion would do much to relieve the situation as regards chronic beds, and I mentioned the Montreal General as an example as to specifically how it would affect us.

COMMISSIONER GIRARD: Ten or twelve years ago, when everybody was talking about the Montefiore Plan, we were all enthused about it, but about five or six years ago some of us were wondering what has become of this

wonderful project and what has been keeping it from developing since it was so good, why hasn't it spread more, and I think at times one of the answers was well, doctors didn't like to go out and do home visits. Now, does this still stand, or would this be an impediment, or what is your opinion about this?

MR. WESTBURY: I would say offhand that a home care program of its very nature is one that should be operated by a large teaching general hospital with the available interne and resident staff. I can well imagine that a small hospital that has not got the available resident staff would not be very enthusiastic about it, and there are, as you know, in the total number of hospitals across Canada there are very few large hospitals that could have the staff available for those duties. I think that is probably the reason why it has not been taken up to the extent we thought it might.

COMMISSIONER GIRARD: One other very important facility for home care is the visiting home-makers.

MR. WESTBURY: Yes.

COMMISSIONER GIRARD: What in your opinion are the facilities that we would have here in Montreal to draw upon a large enough number of visiting home-makers?

DR. STORRAR: This is a very difficult one. There are very few, of course, available, but I would think with the development of such a program that there should be a training program for this type of people, but I would agree that at this minute these visiting home-makers are very scarce because there has been nothing

organized. I think somebody has to start this somewhere.

COMMISSIONER GIRARD: Thank you very much, Mr. Westbury and Dr. Storrar. I hope you do start one.

MR. WESTBURY: If we can get the money we will.

COMMISSIONER GIRARD: Ask again.

COMMISSIONER FIRESTONE: Dr. Storrar, do you treat in the Montreal General Hospital out-patient department indigents?

DR. STORRAR: Yes, we do.

COMMISSIONER FIRESTONE: If the examining physician decides the indigent requires drugs are they provided?

DR. STORRAR: Yes, they are provided from our own funds.

COMMISSIONER FIRESTONE: Provided free from charge?

DR. STORRAR: Provided free of charge if the patient is indigent. If the patient is semi-indigent, they will pay a pro-rated basis, probably from 50¢ to $1.00.

COMMISSIONER FIRESTONE: If a person is examined by his own physician and prescribed some expensive drugs and the person says to the doctor I haven't got the money to buy these drugs, the only alternative the person would have, one alternative that person would have would be to go to the out-patient department of the Montreal General and be examined a second time and get these drugs free or partially free.

DR. STORRAR: If the patient on a

screening was found to be not able to afford to see a doctor privately he would have his drugs, that is true.

COMMISSIONER FIRESTONE: Thank you very much, sir.

THE CHAIRMAN: Thank you very much, gentlemen.

MR. WESTBURY: Thank you, sir.

THE CHAIRMAN: The information you have given us was the information we requested. We are grateful to you for having accepted our invitation and for going to the trouble in providing us with this information. Thank you.

THE CHAIRMAN: We will have the submission of the Canadian Mental Health Association, Quebec Division.

THE SECRETARY: That will be Exhibit No. 230.

---EXHIBIT NO. 230: Submission of the Canadian Mental Health Association, Quebec Division.

APPEARANCES:

LT. COL. S.C. HOLLAND, PRESIDENT
PAUL-MARCEL GÉLINAS, GENERAL DIRECTOR
DR. A. MacLEOD, CHAIRMAN, SCIENTIFIC PLANNING COMMITTEE

LT. COL. HOLLAND: Mr. Chairman, Members of the Commission, if I may introduce my associates. On my right is Dr. Allister MacLeod, Chairman of the Scientific Planning Committee and on my left is Paul-Marcel Gélinas, our Executive Director.

I think you will find, ladies and gentlemen, that the brief which we have submitted at this time is slightly different from the two preceding ones in that we are mainly interested in trying to keep people out of hospitals. I would ask, with your permission, that Mr. Gélinas present the first part of our brief.

MR. GÉLINAS: Mr. Chairman, madam, Members of the Commission, by your leave I will read the introduction in English, even though we respect the by-linguant character of this Province. In order to facilitate

your work I will read in English. You will note the first part of the brief is in French and the second is in English.

The Quebec Division of the Canadian Mental Health Association was founded in 1956 as a Division of the National Association which had been incorporated under a Federal Charter, in December 1926.

On the eighth of May 1961, the Lieutenant Governor of the Province of Quebec granted a Provincial charter under the third part of the Companies' Act to the Canadian Mental Health Association, Quebec Division.

THE CHAIRMAN: I take that means it is a non-profit organization?

MR. GÉLINAS: Yes, that is right.

The Quebec Division in conjunction with the (national) Canadian Mental Health Association and the other Canadian Divisions works toward

the promotion of the most efficient programmes relative to the prevention of mental illness, the treatment and the rehabilitation of the mentally ill and the realization of these objectives by:

1 - public education and information

2- services to the mentally ill and their families

3- social action

4- research.

The way we proceeded in preparing this brief has posed limitations.

The Canadian Mental Health Association,

Quebec Division submits this brief as one coming from a private, voluntary organization. It describes the problems as they appear in the Province of Quebec without any pretense of giving scientific explanations as to their technical or economic aspects.

However, it is basic to the Association that it concern itself with the evaluation of the needs for and the co-ordination of mental health services in order that it may intelligently guide its educational programmes and social action.

Concerned with prevention and treatment relative to mental illness and the rehabilitation of the mentally ill in the Province of Quebec, the Association places before the members of the Royal Commission on Health Services its knowledge of the community needs of the people of the Province of Quebec and of the services in existence. It supports its recommendations by a survey of psychiatric and mental health services in the Montreal and metropolitan region and a directory of mental health services in the Province of Quebec.

Mr. Chairman, I would ask permission to table these reports. I brought a copy for every one of the Members of the Commission plus a copy for the secretary. The same with the Directory. These are the very last copies we have in the Association because the report was presented in 1960. The whole brief is presented on this report, and this is very new out, published only a month ago. I am pleased to place these at your disposal.

THE CHAIRMAN: We are very pleased to have them here. They will be Exhibits 230 A and 230B.

---EXHIBIT NO. 230A: Montreal and Metropolitan Region Survey of Psychiatric and Mental Health Services.

---EXHIBIT NO. 230B: Directory of Mental Health Services in the Province of Quebec.

Although the Association has left the analysis of the technical and economic aspects of the problems of mental illness to more competent groups, it considers that it has a responsibility to submit a Brief covering those areas in which a voluntary association has a major role to play.

Actually this major role is the education of the public and this is part of every facet of the Association's work. This educational role is the common theme of the eight sections which make up this Brief, namely: Administration, Education, Prevention, Treatment, Research, Training, Rehabilitation and Finances and Insurance.

The majority of these sections have been divided into statements and recommendations setting forth the Association's view.

The Association has included a brief summary of its knowledge regarding the attitude of the public toward mental illness, with the belief that the Commission might find it of interest and pertinent, which I'll read now.

S E C T I O N S

1. Administration

2. Education

3. Prevention

4. Treatment

5. Research

6. Training

7. Rehabilitation

8. Finances and Insurance.

THE PUBLIC'S CHANGING
ATTITUDE
TOWARD MENTAL ILLNESS

The attitude of the people has always governed the treatment of the mentally ill. Historically the mentally ill were simply and completely abandoned, rejected by society. This was followed by a more humanitarian approach when the mentally ill were given humane custodial care but were kept apart and forgotten. This was already begun in the 1900's when Pennell began to do this work. More recently treatment, the result of great scientific advances and the partial recognition by the public that mental illness can be cured or controlled has been the major objective of the professional groups concerned with priority care for the mentally ill.

To fully understand the problem in the Province of Quebec one must never lose sight of the fact that the responsibility for Health and Welfare Services were channelled to private institutions while in the rest of Canada provincial governments followed the spirit and pattern of the Elizabethian Poor Law in the development of such services. This has meant in practice that necessary assistance and treatment has been in this province a matter of charity and not of right by law. On the other hand the

absence of legal restraints has permitted certain voluntary agencies to develop exemplary services in the field of mental health which have been slow to develop in those areas where the programs have been centralized and formalized.

In 1845 the first mental hospital in the province, St-Michel-Archange Hospital was founded in Quebec City followed by the St-Jean-de-Dieu Hospital in Montreal in 1873 and the now Verdun Protestant Hospital in 1890, to single but a few. Thus, great sprawling institutions were built as far away as possible from the center of the cities wherein custodial care and, later, treatment was given. During the last two decades mental patients have been given treatment in General Hospitals. From then on the pattern rapidly improved. Treatment and prevention were recognized as paramount, new drugs and techniques were used and new clinics and services were established.

Although the Association is furthering this trend toward the treatment of mental illness it feels that it has a still more important role in fostering an active and dynamic public attitude toward positive and effective mental health. Now, this part I would like to turn over to the President of the Association.

LT. COL. HOLLAND: With your permission I would ask Dr. MacLeod if he would carry on with the administration in the next few paragraphs.

DR. MacLEOD: Under Administration the following recommendations are put forward. To provide necessary leadership, coordination and development of psychiatric services, it is recommended that a Government Commission, having jurisdiction over all psychiatric

[illegible]

[illegible]

mental health [illegible]

areas where the programme has been [illegible]

In 1969, the [illegible]

the province, [illegible]

Quebec City [illegible]

Montreal in 1970 and [illegible]

1969, to support [illegible]

clubs were built in [illegible] way as [illegible]

of the office [illegible]

was given. [illegible]

have been given [illegible]

on the [illegible]

were [illegible]

were used [illegible]

Attempt to Introduce [illegible]

this trend [illegible]

that it has [illegible]

active [illegible]

effective [illegible]

been over to the [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

services be created immediately. I would like to say in choosing the word "jurisdiction" it was meant to have the widest possible range of meaning and we didn't intend for a moment legal control, complete legal control over the hospital.

This Commission should consist of three psychiatrists qualified in psychiatry and administration, assisted by consultants in psychology, social work, nursing, occupational therapy and statistics with the necessary clinical and administrative personnel.

THE CHAIRMAN: I understood there was a report recently in the Province of Quebec dealing with mental illness. I know your brief would have been prepared far prior to the reception of the report. Does that report adopt this recommendation of yours?

DR. MacLEOD: I think so, if you are referring to the Bedard Report. The recommendations are in line with the recommendations of the Bedard Report. I might say, sir, that one member of the Bedard Report is the Vice-President of the Scientific Planning Committee of the Canadian Mental Health Association of Quebec, Dr. Roberts.

On education, our statement is, one of the objectives of the Quebec Division is the promotion of mental health by carrying out public education programmes in order:

1. that the promotion of mental health be as common and general as the promotion of physical health and fitness.
2. to create a favourable climate in the public's

[illegible] I would like to say in closing two words. [illegible] widest possible [illegible] a moment legal [illegible]

[illegible]

These legislations [illegible] tion, assures by [illegible] writing, [illegible] necessary [illegible]

CONCLUSION

A report [illegible] mental illness. [illegible] far prior to the [illegible] adopt this recommendation [illegible]

THE METHOD

[illegible] referring to the [illegible] In line with the [illegible] I might [illegible] the Vice-Pres[illegible] the Canadian [illegible] Robson.

In conclusion, our [illegible] the objectives of the [illegible] mental health in [illegible] in [illegible]

1. [illegible] and [illegible] in the [illegible]

2. [illegible]

mind so that it may understand and help the mentally ill.

3. to educate the family of the mentally ill by appropriate means such as pamphlets, lectures and films.

4. to inform allied professions as to the services available.

5. to carry out educational programmes in the hospitals through its volunteers and its membership of about 5,000 persons.

6. to help the police in its own educational programmes relative to the handling of the mentally ill.

RECOMMENDATIONS:

The Association feels that the above educational programmes should be expanded and that government financial support would help such expansion.

The Association feels that the people of Quebec should be given as much help as possible to understand the kind of services now in existence and the need for other psychiatric services.

An expansion of the educational programme for Industry, through its management staff and industrial physicians would be beneficial.

P R E V E N T I O N

To reduce the incidence and prevalence of mental illness is one of the aims of the Quebec Division of C. M. H. A.

After having made a survey on needs and psychiatric services in Montreal, the Association, I

refer to the Silverman, Groulx Report, sir, has initiated and financed a Psychiatric Emergency and Home Treatment Service in its fight against mental illness.

RECOMMENDATIONS

1.- Prevention or diagnosis would be helped by the creation or expansion of:

Mental Health Clinics
Family Guidance and Counselling Clinics

2.- Prevention and early detection in the schools of the Province by more adequate services is strongly recommended.

3.- Community recreational, educational and service programmes should provide adequate and continuous help for incipient psychiatric problems.

4.- Adequate evaluation of offenders and appropriate rehabilitation programmes for offenders should be provided.

5.- Increase of in-service training programs for Police and those concerned with penal administration.

On treatment our statement is that considering the fact that out of the 22,000 beds reserved for mental patients, 11,000 are used for custodial care only, it would seem that greater treatment facilities should be provided. This is further accentuated by the fact that many persons are awaiting admission.

Most of the professional services in the Province (about 90% of them) are located in Montreal and Quebec cities. The rest of the Province lacks adequate services.

RECOMMENDATIONS

It is felt that decentralization of psychiatric centres would be desirable, in order that the community be served.

1. By smaller hospitals with their own boundaries.
2. By expanding the hospitals giving treatment, throughout the Province. As the situation now stands about 90% of all the hospitals giving treatment are in Montreal or Quebec City.
3. By having a Psychiatric Unit attached to all General Hospitals.
4. By finding ways and means to facilitate admissions.
5. By expanding occupational therapy facilities.
6. By giving continuity of care in order that the patient be followed throughout his illness by one doctor or psychiatric team.

R E S E A R C H

STATEMENT

More social research is needed to fully understand the family, social, community and economic aspects of mental illness.

A survey of existing psychiatric services is needed in the whole of the province. Such a survey should include not only hospital services, but clinics, social agencies, homes, religious institutions, etc.

Medical research in the field of mental illness, which covers a multiplicity of mental disorders or disturbances is far behind medical research in the field of physical illness.

RECOMMENDATIONS

A province-wide study of needs and services should be carried out on which to base a more comprehensive plan for the fight against mental illness.

Funds should be made available for Research in the field of Mental Illness commensurate with the funds now available for physical illnesses.

That an ongoing evaluation of all programmes be set up in order to assess the effectiveness of established services.

T R A I N I N G

STATEMENT

While public education programmes are being developed by private Associations, the training of professional personnel should be carried out on the same level in order to meet the demands created by the education of people.

This applies to such groups as

Physicians
Psychiatrists
Psychoanalysts
Psychologists
Sociologists
Nurses
Occupational Therapists
Social Workers

RECOMMENDATIONS

Considering the existing comparatively small number of specialists it is recommended that:

1. Greater incentives be provided in order to attract more applicants.
2. More bursaries be granted in order to increase the number of applicants and students.
3. Training facilities should be expanded throughout the province.

4. Clinical facilities for students should be expanded.

REHABILITATION

STATEMENT

A mental patient's full recovery depends on early detection, treatment and rehabilitation. Each has its equal measure of importance. Rehabilitation depends to a great extent on the existence of certain forms of physical factors or of attitudes, forming a bridge between the hospital and the community.

RECOMMENDATIONS

1. The establishment of Community Rehabilitation Centres, where social and occupational rehabilitation would be fostered.
2. Discharged mental patients should have the active help of a special agent or agency like the National Employment Service.
3. Community services should be established, solely for discharged mental patients, with the objectives of:
   a) Assuring occupational placement, when deemed necessary, possibly by a period of training or time spent in a sheltered workshop.
   b) Obtaining adequate living arrangements.
   c) Paying particular attention to assignment and assumption of significant social roles and social activities.
4. Educational measures relative to rehabilitation should be taken toward:

a) Professions allied to the care of mental patients.

b) The public - - in order to create a greater acceptance of discharged mental patients.

c) Industry - - to create a favourable attitude towards re-employment.

F I N A N C E S A N D I N S U R A N C E

STATEMENT

1.- It is regrettable that psychiatric hospitals are not included in the Hospital Insurance Plan.

2.- The per diem allowance for General Hospitals is between $17.00 and $22.00 in the Province, while it is $2.75 for Psychiatric Hospitals.

RECOMMENDATIONS

Hospital Insurance should include Psychiatric Hospitals. The per diem allowance for Psychiatric Hospitals should be commensurately increased.

THE CHAIRMAN: Thank you, Dr. MacLeod. Now, in connection with your recommendations under the heading of research where you say that a province-wide survey of needs and services should be carried out on which to base a more comprehensive plan for the fight against mental illness. Are you suggesting that as additional to the survey just completed in the Province of Quebec?

DR. MacLEOD: I think it was not of the same nature. I think the nature of the one here, the Silverman-Groulx was covering the mental health for both English and French, it was designed to discover the needs

of mental health, to study the ways in which it could be improved and what further services they could make use of and, finally, to make recommendations concerning an increase of such service.

THE CHAIRMAN: You think a new survey, the one you propose, should go beyond that?

DR. MacLEOD: We are going in on the basis of only how to handle such a problem, how to make any constructive finding.

THE CHAIRMAN: I note that in your statement you have made no reference to a health services plan of any kind and I am not suggesting that you should have done so. However, on the basis that health services plan should come into being, what is your view on the question of the including of psychiatric services part of the plan? I was thinking of a prepaid plan.

LT. COL. HOLLAND: I think our feeling has been pretty well expressed as it has already been expressed by the reports that the mental health is Canada's number 1 health problem, and, therefore, it belongs to all types of plan under the health plans.

THE CHAIRMAN: I was wondering what position you were taking as to whether it should be dealt with as a separate illness or just as another illness just the same as organic illness.

LT. COL. HOLLAND: I think Dr.MacLeod could answer that better from a scientific point of view. In our work we have tried to impress on the public, because we are an educational institution, that mental illness is an illness and should be treated the same as any other

general health problem.

DR. MacLEOD: I would like to say that obviously with the illness it presents some unique characteristics and we cannot say, you cannot have a general service for a given situation when you have not got a general disorder but by and large, we would like the public to recognize that there is nothing more unique about mental illness than there is about physical illness. Many of the people in the hospitals for people suffering from mental illness are really the aged, chronically infirm and at that level I think our treatment would overlap with the care for the chronic patient even though they are not the same.

COMMISSIONER BALTZAN: I have no questions, I was interested in what you said, but I have no specific questions.

COMMISSIONER FIRESTONE: Just following up the question that the Chairman just raised, if there comes into existence in Canada a prepaid medical care plan should such a plan include medical service for services concerning mental health?

DR. MacLEOD: I feel only competent to answer as an individual and I believe it should. This view is not necessarily shared by my colleagues who have more experience than I recently in the field of treating mental illness.

COMMISSIONER FIRESTONE: As a layman, Mr. Holland, how do you feel?

LT. COL. HOLLAND: I think I explained earlier, as far as we as lay people are concerned, our

major job is to convince the public mental illness is another form of illness and, therefore, should be included in all types of health programs.

DR. GÉLINAS: To answer part of this question, I think the field of psychiatry has been somewhat centralized and in the increases in this service right now the Association along with all these reports have suggested that this centralization takes place an integration of the feel of psychiatry within the general medical scene.

COMMISSIONER FIRESTONE: Dr. MacLeod, in the section on prevention you have one recommendation under number 2 and you say prevention and early detection in the schools by more adequate service is strongly recommended. What does the recommendation include? Annual checkups in schools by competent psychiatrists?

DR. MacLEOD: I would like to say it was ultimately aimed at such an ideal situation but in many ways the general physician with psychiatric training in his undergraduate years, certainly the public health nurse and nurses such as the V.O.N. and the school teachers are very capable in detecting a disturbed child. Of course, the diagnosis of what is disturbing him then becomes the province of the psychiatrist.

COMMISSIONER FIRESTONE: If I understand you correctly the recommendation would be that children should be examined once a year and if any mental disturbance is found that case should be referred to a psychiatrist, is that the proposal you would be in favour of?

DR. MacLEOD: Yes, if I could draw

your attention to the fact that some school systems have very excellent school programs but in general I would like to say yes to your question that we think it would be an improvement that every time the school population is given a routine examination the health examination should include a mental health as well as physical examination.

COMMISSIONER FIRESTONE: And where there is no annual examination you would recommend such an examination should be also annual?

DR. MacLEOD: I would rather say periodical because there is some evidence one cannot have it done annually but that would depend on what the medical officer of health would do.

COMMISSIONER FIRESTONE: Speaking as a scientific planning officer what is your definition of periodic?

DR. MacLEOD: I would say that it would be in the kindergarten, in graduation from kindergarten to secondary school and from secondary school to high school and on to an employment and then at university. Of course, it would depend on the services available and the number of people competent to carry out this service. We would certainly like to aim at the ideal of once a year.

COMMISSIONER FIRESTONE: And if as a result of this examination cases are found requiring psychiatric treatment, what sort of follow-up would you visualize which you stated in your report?

DR. MacLEOD: Many cases of maladjustment in children in school is exposed by them being non-adjustors, that is possessing adequate I.Q.'s but just not

doing anything with it and their conditions must be carried with psychiatrists and psychologists who have special training. There are no special services for these things.

On the other hand, quite a number of children are suffering from minimal organic brain damage,from early psychiatric disorders, from familial and social isolation and so on. I would have to say that while in the Province of Quebec there are one or two centres where the standard of treatment is of the highest in the country, we must assume many, many thousands of school children are not receiving the treatment they should at the moment because of lack of facilities and staff.

COMMISSIONER FIRESTONE: How could this be achieved?

DR. MacLEOD: I do not think it could be achieved on the basis of turning out more specialists. Some method would have to be worked out whereby the specialist would be in consultation with people who would be giving the direct service to the children, for instance, it has been found out by working with the families or the school and checking and in this way you sometimes get a considerable improvement in the child, you have mental behavior. A maladjusted child is one suffering from a psychiatric illness.

COMMISSIONER FIRESTONE: I am just looking for a concrete way of coming to grips with it. You say more psychiatrists is not the solution, how can one proceed?

DR. MacLEOD: I think the first step

should be in the teacher training college. The teacher would be given specific information about this discipline. There should be special programs for the training of school psychologists and school specialists in the matter of mental health.

COMMISSIONER FIRESTONE: Thank you very much.

THE CHAIRMAN: Thank you very much, gentlemen.

LT. COL. HOLLAND: I had hoped that some question might have been asked on the psychiatric emergency and home treatment service which was referred to in the paragraph under prevention by Dr. MacLeod. We have a very brief summary of what has been accomplished or what was started in the Notre Dame Hospital, started as a project in emergency home treatment. The major project is to find the minor mental cases and keep them out of hospitals. We have since had applications from twelve other major hospitals in this city to try and have the same type of service because of the fine results accomplished in the Notre Dame Hospital. Finances, of course, are very important and we have applied both provincially and federally to try and get support, but it is the same old story, lots of congratulatory messages but nobody coming across with the necessary funds to do it.

If I might table a copy of a small statement dealing with this matter.

THE CHAIRMAN: We will be happy to have that and it will be put directly into the record.

PSYCHIATRIC EMERGENCY AND HOME TREATMENT SERVICE

The Quebec Division of the Canadian Mental Health Association has officially launched its Psychiatric Emergency and Home Treatment Service, for those suffering from mental illness.

The idea for this service germinated from the Survey of Mental Health Services, sponsored by the Association and conducted by the two Welfare Councils. The Scientific Planning Committee, which plays the role of advisor to the Board of Directors of the Association, accepted the pilot project and recommended that it first be operated in conjunction with Notre-Dame Hospital.

As part of its policy C.M.H.A. will finance the service at Notre-Dame Hospital for a period of two years, as a pilot project.

Broadly speaking the project reproduces the Home Treatment Service already in existence in Amsterdam and in Boston. The service consists of a full time psychiatrist and a social worker who function as a team. If possible this team will be enlarged but in all cases it is backed by the full resources of the Notre-Dame Hospital psychiatric facilities. The team can only operate in the area covered by the hospital and thus serves 150,000 people of Montreal. The team evaluates all cases brought to its attention and where hospitalization is not indicated the patient is treated at home, in his own family and community environment.

Following the aims of the Association of promoting mental health and preventing mental illness the Service accomplishes the following objectives; the mentally disturbed are taken care of at the very onset of

the disease; where possible they are removed from the community and rehabilitation is thus far easier; imprisonment may often be averted; the family and the community receive direct education in regard to mental illness and mental health; hospital beds are freed for those who have a greater need for them.

This service is the first of its kind in Canada.

It is the Association's hope that, in the near future, similar services will be established in other hospitals, which have already expressed their interest in providing this type of Service.

The Home Treatment Service is not envisaged as an instrument to eliminate hospitals for the mentally ill but rather as a complementary service for patients who do not require hospitalization.

MR. GÉLINAS: We know you are pressed for time, but we have put into your hands the directory for the mental health service of the Province of Quebec. Now, this is not only a referral with office numbers and addresses, I think it is quite revealing by itself. A quick look at it would show you that inthe Province of Quebec we have fourteen mental hospitals with a total number of beds of 21,000 and we have general hospitals that come up with a total of 400 beds; we have nursing homes coming up with the total of 1500 beds for a grand total of 23,200 beds in the Province of Quebec dedicated or reserved for mental illness in mental hospitals. The general point of view taken out of this report is that 90% of the services and given in Montreal City and Quebec

City. There is a tremendous lack of services in the rest of the province. Hospitals that are located outside of Montreal and Quebec do not provide any treatment at all except for good custodial care. The general hospital located in Montreal and in Quebec in number of eighteen -- it is five cities that have general hospitals with psychiatric units and the rest of the province has a public education body. We are quite interested in enlarging or developing public opinion that would help us or would help create a political influence to extend services or decentralize the services and make it available to all units in general hospitals. An Association, a private Association like us cannot do it alone, needs the help of the Provincial and Federal Governments.

THE CHAIRMAN: I was going to say the Commission is very much concerned with this problem of mental illness and it is one of the subjects which we are making special studies of. We have commissioned two special studies in this field alone and your submissions and the supplementary material that you have filed with us today will go to our project directors as well as the evidence we have heard here today. To that extent, perhaps, we do not perhaps make as minute an investigation because we have set up these two special commissions to look into this one subject.

LT. COL. HOLLAND: As a closing remark I would like to assure the Board Members of the Commission that my lack of large words today is not an indication of my lack of enthusiasm for the work we are doing merely because I feel my associates could answer the

questions a lot better than I.

THE CHAIRMAN: We have had a very helpful afternoon with you and are very grateful for your submission.

We will take a short recess now.

---Short Recess.

SUBMISSION OF

THE ASSOCIATION OF GENERALISTS OF THE MEDICAL DISTRICT OF MONTREAL

APPEARANCES:

DR. GERARD HAMEL

THE CHAIRMAN: This will be Exhibit No. 231.

DR. HAMEL: We appear here before a Federal Commission which is authorized to conduct an inquiry on health services presently given to Canadians, and secondly to make recommendations on measures designed to improve these health services. Even if we recognize the participation, or the assistance of State should be done exclusively by the Provincial Government, nevertheless we are aware that the results of this survey may be used as a reference source by the Provincial authorities, whether they be medical or governmental authorities.

Our Association includes all general practitioners in the District of Montreal. In other words, the territory covering the whole of Montreal and the south bank of the St. Lawrence River. The population served represents about one-tenth of the entire Canadian population. The quality of medical care given by the general practitioners can be considerably influenced by conditions. This justifies in our brief the description of an abnormal situation in Montreal, which jeopardizes the practice of medicine by general practitioners.

Recommendations.

1. Respect of freedom of choice of doctor by the patient;

2. Doctors ought to be remunerated suitably for the time they devote to teaching;

3. Diagnosis centres should be created as soon as possible so as to lessen useless hospitalizations and to allow doctors to make more exact diagnoses.

4. Integration of the general practitioner into all general hospitals, affiliated or not with the university, for in order to be up to date and to improve himself, the general practitioner must frequent the hospitals;

5. Reappraise general medicine by the methods recommended on page 8 of the brief;

6. Make general medicine more attractive so as to direct as many doctors as possible towards this branch;

7. Better distribution of specialized medical personnel across the Province.

These are general recommendations concerning health insurance plans.

1. The patient must go first of all to the general practitioner. If he consults a specialist straightaway, the latter ought to receive the same fees as the general practitioner;

2. That the doctor be paid for medical attention and the scale of fees fixed in advance between the insurer, the doctors and the insured persons, right from the beginning under professional control;

3. That the scale of fees be established in accordance with a general system of classification for medical attention;

4. That this scale of fees be the result of a serious economic inquiry in line with criteria stipulated in our memorandum;

5. Payment for medical attention must be made with regard to the service rendered and not with regard to the person who renders it: for equal medical services, equal fees.

THE CHAIRMAN: Will you be good enough to explain general recommendation number 5, the payment for medical attention.

DR. HAMEL: Payment for treatment should be made on the basis of the service rendered and not with regard to the person who renders it; equal pay for equal treatment. On page 22 we give a further explanation.

THE CHAIRMAN: Did you say that the general practitioner should be paid as a specialist is paid?

DR. HAMEL: No, differently. First we should look at the distinction between the fees paid in a given specialization. As an example we might mention that surgical fees for example, an apendectomy should be the same for all surgeons. In the same way we should consider fees paid for a treatment that can be given both by a general practitioner and by the specialist. Even in these cases the fees should be the same, because the service given is the same regardless of the person who gets the service. We can give an example. If you want to

vaccinate a child, first you must be sure that the person who is going to vaccinate the child is competent to do so, once this is recognized, it must be considered whether the treatment is given by a specialist or general practitioner, the criterion of the treatment is the type of service rendered, and in this case the service consists of the child being vaccinated.

THE CHAIRMAN: On page 17, number 4, integration in all general hospitals. Are there hospitals which are closed to your members?

DR. HAMEL: Yes, sir. In the Montreal region we have a very serious problem, because patients have at their disposal around 9,000 beds. These beds consist of university hospitals which have a capacity of around 5,000 beds. This means that these hospitals can in most cases, that is in about 95% of the cases cannot be treated in hospitals.

THE CHAIRMAN: In which hospitals do they have their patients treated?

DR. HAMEL: Well, they are obliged to send their patients requiring hospitalization, they have to ask the police to have them entered in hospitals, or they have to go to the hospital dispensaries. In these dispensaries the patients are treated by the resident physician in the hospital. It is a daily experience in the practice of a general practitioner in Montreal.

THE CHAIRMAN: On Friday afternoon we heard that there are several private hospitals, that is hospitals having a capacity of less than 25 beds, in Montreal and in the surrounding area. These small hospitals,

are they accessible to your group?

DR. HAMEL: Well, sir, in the Province of Quebec out of 25,000 beds in the general hospitals, 23,500 beds are in the public hospitals, and about 1500 are in the private hospitals. If all the private hospitals in Quebec were open to general practitioners, it would still be insufficient. We cannot foresee that the private hospitals could furnish a solution to the problem of the general practitioner. The few private hospitals existing in the Montreal region are accessible to general practitioners, and also in certain cases the specialists. We know a great number of specialists, particularly obstetricians, who do deliver even in these small private hospitals.

COMMISSIONER GIRARD: Dr. Hamel, on page 17 in the French text, under Paragraph 3, where you advocate diagnosis centres. Can you tell the Commission where should these diagnosis centres be established, who should establish them, and how will they be financed?

DR. HAMEL: In our idea, the place where they should be established is less important than the way in which the diagnosis is made. As we see it, diagnosis centres should be a centre to which the patient will be referred if he requires some extra examination. Once such an examination is made, the patient will come back to the general practitioner with the result. Such a centre could be organized within a hospital, or outside the hospital, but as to financing, as a result of the hospitalization program in the Province of Quebec, we feel now that these diagnostic centres should be financed in the same way as the hospital insurance is financed.

COMMISSIONER GIRARD: Well then, you are not opposed to setting up these diagnostic centres in the out-patient clinics, and to having these centres financed by the Hospital Plan system?

DR. HAMEL: Well, provided that the patient has a prescription from his own physician in order to obtain admission into these diagnostic centres. Without such a prescription many patients will go directly to these centres to have themselves X-rayed, or to obtain laboratory analyses, and this may be very costly to those who are obliged to pay for this. Secondly, the general practitioner in other cases may also lose his patients through this procedure, because it might cause certain general practitioners to lose their patients.

COMMISSIONER GIRARD: Well, it is understood that the patient should only come to a centre with an authorization from his doctor. Once he has obtained an analysis he should, of course, go back to the doctor who sent him to the centre, and this personal doctor will act accordingly.

DR. HAMEL: Yes.

COMMISSIONER GIRARD: On page 18, under number 2 of the French text, you say that the doctor should be paid according to treatment given, and then thereafter you say that the fees will be set up according to a listing. Who will set up this listing of medical fees?

DR. HAMEL: Well, this scale of fees should be established under professional control. Control may be exercised by the College of Physicians, or perhaps by specialists with the help of economists or experts in

the field. However, in any case this listing should be placed under professional control.

COMMISSIONER GIRARD: Could you explain somewhat further as to the procedure of remunerating, the payment made for the treatment given?

DR. HAMEL: Well, the elements of the system which we have put in the appendix to our brief were inserted to show the relative value of individual medical treatments in the listing of types of medical treatment, and we say that all treatment can't be classified according to a certain factor. This factor will determine the relative value of a given treatment. For example, if an appendectomy is conducted this appendectomy will be considered thirty times as valuable as an ordinary consultation. In other words, the value of each treatment will be designated according to a system of relative evaluation. Very often a certain difficulty arises for a physician to establish a fee for a treatment. One specialist would charge $150.00 for an appendectomy, another $200.00, $250.00 or $300.00. This varies with the particular specialist.

COMMISSIONER GIRARD: In setting a scale, do you take account of the time element, or do you take account of the person giving the treatment, or do you combine all the elements?

DR. HAMEL: Well, we combine a number of elements here in the listing of treatments as it exists in France, and of course we don't suggest that this plan be adopted in the Province of Quebec as it stands. It can be modified and adapted to our own conditions here, but we have seen in this listing that there are a great many

the field. Lawrence, in his case [illegible]
[illegible] proceedings [illegible].

[illegible]

[illegible]

Mr. Fowler: Well [illegible]
[illegible] we have [illegible] to [illegible]
[illegible] to [illegible] the [illegible]
[illegible] in the [illegible] of [illegible]
and [illegible] that [illegible] [illegible]
to a certain [illegible]. This factor will [illegible]
relative value of [illegible]. [illegible], it is
appropriate in conjunction with [illegible]
thirty times as valuable as [illegible].
other words, the value of [illegible] will be [illegible]
according to [illegible] [illegible].
[illegible] for a [illegible]
a fee for a [illegible]. [illegible]
or [illegible] [illegible] [illegible]
this varies with the [illegible].

[illegible] a
scale, [illegible] of the [illegible]
[illegible] of the [illegible]
[illegible] of the [illegible].

Mr. Fowler: Well, [illegible]
of [illegible] in the [illegible]
or [illegible], [illegible]
[illegible] in the [illegible]
[illegible] and [illegible]
[illegible] in this [illegible]

1 midwives working in France, whereas in Quebec we have
2 auxiliaries of a different type. We therefore included
3 this appendix in our brief in order to suggest that a
4 similar listing or nomenclature could be set up in the
5 Province of Quebec.
6 COMMISSIONER GIRARD: You say establish
7 or set up. Well, who should establish it?
8 DR. HAMEL: In France this was set up
9 by a tri-partite commission, including financial, economic
10 experts. They also called physicians and representatives
11 of social security agencies. In the Province of Quebec I
12 believe the medical profession could call in also such
13 outside experts as was done in France, in order to set up
14 a similar nomenclature or listing.
15 COMMISSIONER BALTZAN: Dr.Hamel, I
16 assure you we are most interested in your presentation.
17 I would like to ask you, somewhere I read that you have
18 eight hundred general practitioners, is that right?
19 DR. HAMEL: Yes, this is true.
20 COMMISSIONER BALTZAN: And 400 of them
21 belong to your organization?
22 DR. HAMEL: That is right.
23 COMMISSIONER BALTZAN: Could you tell
24 me how many of the 400 that you know have hospital privi-
25 leges?
26 DR. HAMEL: About half of them, or
27 somewhat less than one-half. Those who are located in the
28 District of Montreal and who practise in the region of the
29 General Hospital, such physicians do have access to general
30 hospitals. Among the other practitioners, who practise

[illegible]

[illegible] Mr. Chairman, I [illegible] similar building or [illegible]

[illegible]

[illegible] us. Well, who would [illegible]

by a tax-exempt [illegible] property. They also called [illegible] of social security [illegible]. In the [illegible] of [illegible] I believe the medical profession [illegible] substitute experts to work [illegible] in Europe. [illegible]

[illegible]

[illegible] I, [illegible] I would like to ask you, [illegible] I read here, we have [illegible] regulated general practitioners, [illegible]

[illegible]

[illegible] belong to your [illegible]

[illegible]

[illegible] how many of the [illegible] you have been [illegible] [illegible]

[illegible]

[illegible] Mr. [illegible] [illegible] Dr. [illegible] Director of Medical [illegible] [illegible] general hospital, [illegible]

around those hospitals which are closed to general practitioners, these others of course, have much more difficulty in having their patients admitted to such hospitals. This constitutes about half of this figure.

COMMISSIONER BALTZAN: What do you say, Doctor, is the reason for the other half not having those privileges, I didn't understand.

DR. HAMEL: Well, I believe that this question should be raised and put to the medical officers of those hospitals. A great many arguments are presented by the medical officers of these hospitals. An Association was recently set up of the medical boards of the hospitals and the universities. This Association was studying ways and means of excluding the general practitioner from the hospital. It is very difficult for me to answer this question because the arguments furnished by these individuals are, in my thinking, not at all reasonable.

COMMISSIONER BALTZAN: You said that they mainly concentrated on setting up ways and means of excluding general practitioners. Did they take up the matter of how to include practitioners?

DR. HAMEL: Well, I should make one exception on this, recently as a result of our efforts and endeavours a hospital of 1100 beds has set aside sixteen beds for general practitioners in that hospital's particular region.

COMMISSIONER BALTZAN: Thank you, Doctor. You mentioned here organizing a system to send persons to first the general physician. Do you make that an optional right or would you state that should be the rule?

DR. HAMEL: Well, this should be the rule, should be compulsory and for several reasons. In the society of the future we have to fear a shortage of doctors, so we must avoid all useless consultation. If a patient first consults a specialist, let us say a cardiologist when he has a bladder ailment, such a patient will involve -- will produce a useless situation because the specialist he consults is trained to deal with more important cases, so by eliminating this treatment we will avoid useless consultation.

COMMISSIONER BALTZAN: You use the word it should be made compulsory. I am not going to ask you how to make that compulsory. I am going to ask you this, at the same time I believe you subscribe to the principle of free choice of doctors on the part of the patient. Does that right not also extend to his privilege and right to choose his specialist if in his own opinion he can get satisfaction there even though his choice may be a wrong one?

DR. HAMEL: Well, we anticipated this question, sir. We state that in cases in which a patient first goes to a specialist the specialist should receive the same fee as the general physician.

COMMISSIONER BALTZAN: I am not going to argue that point at the moment. Elsewhere you say we feel that the Medical Board of the Province --- that is a little bit new to me. What is the Medical Board of the Province of Quebec?

DR. HAMEL: What page are you referring to, sir?

[illegible]

the society of the [illegible] to [illegible]
[illegible], as we [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
with [illegible] -- will [illegible]
the [illegible] [illegible]
[illegible] [illegible]
avoid [illegible] [illegible].

[illegible]

word it [illegible] be made compulsory. I am not [illegible] to [illegible]
you now to make this compulsory. I [illegible] [illegible]
this, at the same time I believe you [illegible] [illegible]
principle of free [illegible] [illegible] [illegible]
[illegible]. [illegible] [illegible]
[illegible] [illegible] [illegible]
be [illegible] [illegible] [illegible]
be a wrong [illegible]

Mr. [illegible]

question, also, we [illegible] [illegible]
light goes to a [illegible] [illegible]
[illegible] [illegible] [illegible].

[illegible] [illegible]

to a [illegible] [illegible] [illegible].
feel that the [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible].

[illegible]

COMMISSIONER BALTZAN: In the English version on page 3, number 3. It is a simple thing, you don't have to look it up. It is only because I am not acquainted with your customs in grading. You say the Medical Board of the Province of Quebec.

DR. HAMEL: I believe there is an error here, sir. It should be Medical Board of the Hospital.

COMMISSIONER BALTZAN: Yes, and obtain such a certificate, the certificate would be proof that the doctor is the holder of certain theoretical and clinical courses.

DR. HAMEL: Well, sir, I believe we are not at the same page. Perhaps the English translation, there is a difference in the numbering in the pages between the two translations.

COMMISSIONER BALTZAN: Page six, number three, Paragraph three.

DR. HAMEL: We mean by Medical Board the College of Physicians and Surgeons.

COMMISSIONER BALTZAN: Is the General Practitioners Association or the General Practitioners of Quebec, are they affiliated with the College of General Practice in Canada?

DR. HAMEL: We share the same views and objectives as the College of General Practitioners in Canada. As a matter of fact most of the officials of our Association are members of the College of General Physicians of Canada, and also officials of the Quebec Division of this College of General Physicians in Canada. However, this

College of General Physicians in Canada, its activities are primarily the reporting of scientific progress of our members whereas our own Association deals also with the economic, social and moral interests of its members.

COMMISSIONER BALTZAN: You feel you cannot call on them to help you out in your local problems as with regard to admissions, privileges for admissions, etcetera?

DR. HAMEL: The College of General Physicians in Canada fully shares and supports our views. We are not speaking of the Quebec Division because the officers are the same in both organizations.

COMMISSIONER BALTZAN: Just a final question, Doctor, have you here in Quebec or, say, Montreal a department of general practice in any of your large hospitals?

DR. HAMEL: Well, at great price we have obtained from some larger hospitals an agreement to set up a department of general medicine, but no such department has been set up in any university hospital, not yet in any case.

COMMISSIONER BALTZAN: In this Department of General Practice a doctor has his privileges to admit the patients. Would that doctor be attached to a single department or several departments?

DR. HAMEL: In hospitals where there is a general practice division physicians, administratively, come under the chief of the general practice department. From a clinical point of view, wherever their patients are they are nevertheless under the responsibility of the

heads of other departments.

COMMISSIONER BALTZAN: How would you fare, or your doctors fare in a hospital that has a general practice department if you have a child you want to have admitted which would go to the Department of Paediatrics and at the same time you have somebody that is to be admitted, who is your patient, a long-time patient and has to be admitted because you suspect you might have to operate on him in the next twelve hours in surgery?

DR. HAMEL: The physician when he treats either a child in paediatrics or when he requires a case in the Surgery Department must submit himself to the regulations of these various departments in which the patient is to be admitted. If the physician treats a patient in paediatrics he must submit himself to the rules of the other members of the Paediatrics Department, and also the paediatricians, but on the other hand from the administrative point of view, that is from the examination of files, of his files, from the point of view of professional ethics, he goes under the head of the General Medicine Department.

COMMISSIONER BALTZAN: I think you could clear up a point, I would still like to see how well these sort of privileges would serve the purpose you want when your purpose is in your daily work to look after things that come under surgery, under medicine, under paediatrics, under obstetrics, and then when you go into the hospital you wouldn't be in a position to treat all your patients.

DR. HAMEL: Well, the general practitioner has no particular status. He remains a kind of

consultant, outside physician. He is not part of the hospital. He is not part of the various boards, of the scientific activities and experience shows that a general practitioner department is the best manner in which a practitioner can be integrated into the hospital and often the only way which this could be achieved.

COMMISSIONER BALTZAN: Thank you very much.

COMMISSIONER FIRESTONE: Dr. Hamel, on page 15 you present the Commission with some basic considerations that you feel should guide us in considering a health insurance plan. In Paragraph 3 you set out some of the reasons that you do consider as to whether such an insurance plan should be compulsory. Now, I understand the reasons that in your opinion are in favour of the compulsory plan; one, universal coverage, two, premiums would be low and three, that there would be administrative efficiency resulting from uniformity of operations. Now, sir, are you in favour of a prepayment principle for medical plans, medical care insurance plans?

DR. HAMEL: Yes.

COMMISSIONER FIRESTONE: Now, sir, you then go on in Paragraph 4 and you say after you have considered all the advantages that a compulsory plan would offer you still feel that you would support a voluntary plan because of the importance which you attach to what you call freedom of action.

DR. HAMEL: Yes, Mr. Firestone.

COMMISSIONER FIRESTONE: You appreciate, sir, that the different groups of people in different

provinces have different views on the subject, and some have expressed views in favour of the compulsory plan and some of a voluntary plan. Now, sir, if the Federal Government, in line with the constitutional division of responsibility offer financial assistance to Provincial plans and ask that these plans should be developed individually and separately for each province and administered in each province and developed in consultation with the medical profession and other groups in the province, if some provinces wished to have a voluntary plan such as you recommend and other provinces wished to have a compulsory plan, would your Association support such a plan which would leave the decision as to whether it should be voluntary or compulsory to the people and the profession in each province?

DR. HAMEL: You put to me, sir, a very delicate question, Mr. Commissioner. In a case of that type I feel that our Association would consult the College of Physicians and other associations in the Province of Quebec before taking a decision, which wasn't done in the past, and I am convinced in the future the relationship between those various bodies will be far more developed, which will enable us all to have similar views on the matter.

COMMISSIONER FIRESTONE: You appreciate, sir, that this Commission will have to offer some advice to the Government on this plan, and we would find it helpful if we could have an expression of opinion as to how you feel. We respect your wishes, that you wish to consult the College of Physicians and Surgeons of the Province of

Quebec before expressing any views. Would it be too much to ask you on behalf of your Association to carry on with this consultation and let us have your views at a later date?

DR. HAMEL: Yes, naturally, Mr. Commissioner, if you will grant us a few weeks time. We havent' had any time to do so up to now, and the submission of our brief is an example of what we can do. We could naturally communicate in a supplementary brief our views on that.

COMMISSIONER FIRESTONE: This would be very helpful, Dr. Hamel. Might I mention to you what the Chairman mentioned earlier at Ottawa. This Commission will have supplementary and final hearings in Ottawa. If it is convenient for you to let us have a supplementary brief we would be grateful. If you wish to appear at the supplementary and final hearings in Ottawa and present those views this will be entirely up to you, as long as we can have your views before the Commission winds up its work.

DR. HAMEL: Our Association is greatly honoured by your kind invitation and I will be most flattered to transmit it to the Executive Branch of our Association.

COMMISSIONER FIRESTONE: We are very grateful to you, and I understand we can expect a supplementary submission from you.

DR. HAMEL: Yes, sir.

COMMISSIONER FIRESTONE: If I may turn now to page 17, Paragraph 3, you state there that diagnostic centres would lessen useless hospitalization. What do you mean by useless hospitalization?

before addressing my views. Would it be too much to ask you on behalf of your organization to carry on with that?

[illegible]

[illegible]

[illegible] of our brief is an example of what we can do. We could [illegible]

[illegible]

very helpful, of course. Might I mention to you that the Minister mentioned earlier in Ottawa. This Commission was [illegible] and final meetings in Ottawa. If it is convenient for, or to ask us have a supplementary brief we would be grateful. If you wish to appear at the supplementary and final meetings in Ottawa and present those [illegible] will be entirely up to you. As long as we can have your views before the Commission when its work.

MR. HARRIS: Our association is generally concerned by your [illegible] and I will be most interested to recommend it to the Executive Council of our Association.

COMMISSIONER HARRISON: We are very grateful to you. I understand we can expect a supplementary submission from you.

MR. HARRIS: Yes, sir.

COMMISSIONER HARRISON: If I may turn now to page 17, Paragraph [illegible] you [illegible] that improvement would lessen unless complaints. What do you

DR. HAMEL: Well, we know with general practitioners there are quite a number of patients pressuring their doctors for admission to the hospital when this involves X-ray or voluntary examinations. I will give you an example, if we suspect a patient of having a stomach ulcer, if we suggest an X-ray for them, the patient will tell us, say, "Doctor, at the hospital it wouldn't cost me anything, will you kindly have me admitted to the hospital". Many doctors, in fear of losing their clients have their patients admitted in the hospital, and this happens, a considerable number of hospitalizations, which we consider useless.

COMMISSIONER FIRESTONE: Now, sir, if the out-patient clinics of hospitals would make it possible to carry out these X-rays and other services could that not meet your requirements?

DR. HAMEL: It certainly would improve the situation in the Province of Quebec, yes, sir.

COMMISSIONER FIRESTONE: Would you be in favour of such an extension of out-patient clinic facilities in the Province?

DR. HAMEL: Yes, certainly, sir.

COMMISSIONER FIRESTONE: May I now turn to your page 18, Paragraph 2, in which you recommend the doctor be paid for medical services and the scale of fees b fixed in discussion between the insurer, the doctor and the insured person. Well now, sir, would your group be in favour of doctors being paid for such services that are insured by the insurer acting on behalf of the insured person?

DR. HAMEL: Yes, certainly.

COMMISSIONER FIRESTONE: Would you feel the fact that an insurance company or insurance commission is paying bills to the doctor that this would not affect the quality of medical care services which a doctor offers his patient?

DR. HAMEL: This will not affect the quality of the treatment given subject to the following conditions: One, that there is to be selected by a committee for accreditation which would control these companies by representatives of the medical profession and of the companies themselves and of the Government. I suggest these insurance companies are subject to that control.

COMMISSIONER FIRESTONE: I take it from what you are saying and please correct me if I did not quite understand your point, that the method by which a payment is made to a doctor does not affect the quality of the medical care services, that what is important is that the doctor gets paid and the scheme that is developed is one that is acceptable to the medical profession but the method of payment does not affect the quality of medical service; is my understanding correct?

DR. HAMEL: I am not prepared to answer yes to that question, I think that some circumstances might affect it.

COMMISSIONER FIRESTONE: Could you give us an example of where it might affect the quality of the service?

DR. HAMEL: As we say in our brief,

[illegible] the fact that an insurance company or insurance corporation is paying bills to the doctor that would not affect the quality of medical care [illegible] when patients?

Dr. MARMOR: This will not affect the quality of the treatment given subject to the following conditions: one, that care is to be delegated by committees for assessment on which work control there is by representatives of the medical profession and of the commercial insurance companies and of the government. I believe these insurance companies are subject to [illegible]

COMMISSIONER FINNSTROM: I have it not quite understand your point. When the method by which a payment is made to a doctor does not affect the quality of the medical care rendered, that what is important is that the doctor gets paid and the scheme that is developed in one case is acceptable to the medical profession but the method of payment does not affect the quality of medical service; is my understanding correct?

Dr. MARMOR: I am not prepared to answer yes to that question. I think that some circumstances might affect it.

[illegible] of where it might affect the quality of the medicine.

Dr. MARMOR: [illegible] in our [illegible]

this method of payment must not be imposed upon the medical profession; the medical profession must be in a position to accept willingly any system of integration so, therefore, all the conditions which come to life to exempt that method of payment could not be accepted.

COMMISSIONER FIRESTONE: Just trying to be helpful to you, let us assume an insurance plan is worked out for the Province of Quebec in cooperation with the medical profession to make sure this plan is efficiently developed or efficiently administered, would your group support a method of payment by this medical agency or medical insurance commission to the doctor directly? You would accept this service assuming that the medical profession has participated in the development of this program and sits on the board and in any other manner that is considered appropriate?

DR. HAMEL: But it will not necessarily be the only insurance company, a single insurance company having a monopoly over the payment for treatment. We believe that several insurance companies should compete in that field. We fear monopoly whether an insurance company or the State, we are against them. We are in favour of competition and in favour of several companies competing with a view to having the best quality.

COMMISSIONER FIRESTONE: But when you say you are in favour of competing plans, do you have in mind both medically sponsored non-profit plans and insurance plan competing against one another, is that what you have in mind?

DR. HAMEL: Yes.

COMMISSIONER FIRESTONE: In what way does this system which you envisage differ from the present situation?

DR. HAMEL: It differs from the present situation in the Province of Quebec.

COMMISSIONER FIRESTONE: Yes, at present you have a voluntary system, at present commercial insurance companies, at present medically sponsored plans. In what way does your proposed plan improve what is aimed at, that is, to achieve universal coverage in the Province of Quebec?

DR. HAMEL: It would be that the treatment would be paid by the State.

COMMISSIONER FIRESTONE: To whom would the premium,be paid?

DR.HAMEL: There you are putting to me a very delicate question.

COMMISSIONER FIRESTONE: Well, we are coming to the medical profession for some advice as to what kind of comprehensive and universal plan should be developed for Canada and the Province of Quebec, if we cannot get the advice from the medical profession, where shall we get the advice from?

DR. HAMEL: You are quite right, sir, quite right to ask the medical profession point of view. However, here I must go back to my initial presentation, my initial statement, that is to say, to make more progress we shall have to consult the other agencies in order to answer your more specific questions.

COMMISSIONER FIRESTONE: Would you be

DR. HAMEL: In addition from the p[illegible]

[illegible] in the Province of Quebec.

COMMISSIONER FITZSIMONS: Yes, so

present you have a voluntary system, at present compulsory at

[illegible] in Quebec, at present medically sponsored plans.

[illegible] do you think your proposed plan improve was it added

[illegible] to extend medical coverage in the Province

[illegible]

DR. HAMEL: It would be that the

[illegible] would be paid by the State.

COMMISSIONER FITZSIMONS: In mind would

[illegible]

DR. HAMEL: There you are putting to me

a very difficult question.

COMMISSIONER FITZSIMONS: Well, we are

[illegible] medical profession [illegible] as to what

[illegible] comprehensive and [illegible] plan should be

[illegible] in Canada, and the Province of Quebec. If we

[illegible] the advice from the medical profession, where

[illegible]

DR. HAMEL: You are quite right, sir,

[illegible] medical profession [illegible]

[illegible] I [illegible] to my [illegible]

[illegible] to do, to make [illegible]

[illegible] to [illegible] order to

[illegible] more [illegible]

COMMISSIONER FITZSIMONS: Would you be

prepared to take this particular question under further advisement and come forward with a specific and concrete proposal of how the program that you have in mind could be put into practical operation in the Province of Quebec including the two questions; one, who would look after the medically indigent, who would administer that part of the plan and how would you achieve universal coverage and how can you find the most efficient operation of the system including the question of payment by the insurance commission company or whatever you may call it, to the doctor. Thank you for your cooperation, I understand you are prepared to present us with these views in a supplementary submission.

DR. HAMEL: Yes, sir, after I have consulted with my associates.

COMMISSIONER FIRESTONE: Thank you very much.

THE CHAIRMAN: Thank you very much, Dr. Hamel, and any further material that you wish to send to us if you will send it to our Secretary Mr. Lafrance he will see that it reaches us.

---EXHIBIT NO. 232: Submission of Canadian Psychological Association.

S U B M I S S I O N O F

CANADIAN PSYCHOLOGICAL ASSOCIATION

APPEARANCES:

FATHER MAILLOUX

DR. ROBERT MALMO

DR. VIRGINIA DOUGLAS

DR. K. G. FERGUSON

THE CHAIRMAN: Dr. Malmo, you are the spokesman?

DR. MALMO: May I introduce the committee that prepared the brief. Father Mailloux is the Chairman and spokesman; Dr.Douglas is another member and Dr. Ferguson is another member of the committee. This brief was prepared by this committee and I think that my main function is to introduce the committee to you because they are the ones that prepared it.

THE CHAIRMAN: Thank you, we are very happy to have you here and to receive this brief.

FATHER MAILLOUX: I suppose I have to read the summary of our recommendations and perhaps put in a few comments to highlight some points.

THE CHAIRMAN: Whichever way you wish to present it.

FATHER MAILLOUX: I will not say we are representing any group in the Province of Quebec specifically,

because we are a national body.

A. Research

Financing Psychological Research

Over the past few years there has been a most encouraging increase in the quantity and quality of psychological research in Canada. As a result, psychologists have been accepting responsibility for a large proportion of research in the mental health area.

Canadian psychologists are well aware of the serious lack of well-documented knowledge on which the care of our mentally ill can be based. A sound program of basic and applied research provides the only answer to this situation. Following are a series of recommendations intended to strengthen the contribution of psychology to mental health research:

1. It is essential that available funds for sponsoring psychological research in Canada keep step with the rapid advances in quality and quantity of research being undertaken by Canadian psychologists. Sponsoring agencies in Canada should give serious consideration to the likelihood of being faced with a larger share of the financial responsibility for Canadian research in the health area.

2. The researcher should be allowed as much scientific freedom as possible. Grants should be administered with an awareness of the fact, that as work progresses, research budgets must often be modified. An investigator should not be required to follow the specific details submitted in his research proposal. If, in the course of his work, he finds promising leads that he

[illegible]

[illegible]

[illegible]

[illegible]

[illegible] in the [illegible] psychological research in Canada. As a result, problems which have been [illegible] for a long [illegible] in an [illegible] way.

Canadian psychologists [illegible] of the [illegible] lack of well-conceived knowledge on which [illegible] can be based. A [illegible] [illegible] organized research provides the only [illegible] [illegible]. Following are a number of recommendations [illegible] to strengthen the contribution of psychology [illegible] in Canada.

1. It is essential that available funds [illegible] psychological research in Canada keep [illegible] in quality and quantity of research [illegible] by [illegible] psychologists. Some [illegible] [illegible] give [illegible] consideration [illegible] of being faced with a larger share of the [illegible] for [illegible] research in the [illegible].

2. The [illegible] should be allowed [illegible] freedom as possible. Grants should be [illegible] with [illegible], that is [illegible], [illegible] [illegible], [illegible] investigator should not be required to follow the [illegible] [illegible] outlined in his [illegible] proposal. It is the [illegible] of his work, he [illegible] [illegible].

believes will be more productive than those outlined in his original proposal, he should be free to follow them. The grants should be sufficiently flexible to enable the investigator to make modifications within his budget so long as his total expenditures remain within the amount allocated to him. Sufficient control of research funds can be achieved by careful auditing of expenditures by the sponsoring agency and by requiring a complete report of research findings.

3. Financial provisions should be made for researchers of established competent to undertake relatively large-scale, long-term research programs.

4. The position of psychologist-researcher should be firmly established in academic, service and research settings. This involves provision for professional status and financial remuneration which compares favourably with the status of service and teaching personnel with comparable training in these settings. It also involves administrative support and encouragement of psychological research in academic and service settings.

5. Granting bodies should take care to avoid too narrow a definition of what is to be considered health or mental health research. Important contributions have been made by psychologists working on applied problems in the health area; significant developments have also come from psychologists whose primary interest is in basic research on human and animal behaviour. Both applied and basic psychological research merit public support.

6. Control of the administration of research grants should be shared by individuals who have

[illegible] effective when their original [illegible] proposal. It should be free to follow them, [illegible] investigator to make modifications within his budget or [illegible] his final expenditure remain within the amount allocated to him. The Health Council of Canada can be approved by carefully auditing or expenditures by the [illegible] agency and by requiring a complete report of [illegible].

2. Financial provisions should be made for [illegible]

3. The position of psychologist-[illegible] [illegible] clearly established in research, service and [illegible] training. This involves provision for professional [illegible] and financial remuneration which compares favourably with the salaries of service and teaching personnel with [illegible] [illegible] supportive support and encouragement of psychological research in academic and service settings.

4. Granting bodies should take care to [illegible] the narrow definition of this to be considered [illegible] of mental health research. Important contributions have been made by psychologists working on specified problems in the health area; significant developments have also come from psychologists whose primary interest is in basic research on human and animal behaviour. Both application and basic psychological research merit public support.

5. Courses in the administration of [illegible] should be [illegible] by [illegible] [illegible]

themselves established research competence. Competence in service or administration does not necessarily qualify an individual to evaluate research investigations. If a sponsoring agency regularly receives a large number of research proposals from the field of psychology, psychologists should have proportionate representation on the committees which evaluate such proposals.

7. Grant awarding agencies should maintain a reasonable balance between, and a clear distinction between, grants for research and grants for service. Research funds should not be used to provide services, no matter how essential the services may be.

B. Service

Recommendations for Psychological Services

Canadian psychologists are currently participating in prevention, diagnosis, treatment and rehabilitation services in the health field. A large part of their work brings them into contact with individuals suffering from emotional and mental disturbances. As a result they have become alerted to serious gaps in our mental health program.

Canadian psychologists are convinced that services in the mental health field must be improved, and that they must be made available to all Canadians. Attempts to bring about improvements in psychological services in the mental health area have been hampered by a number of factors including a serious shortage of trained personnel and problems involved in establishing an acceptable professional role in service settings. Following is a group of recommendations concerning service needs in the mental health area:

service or administration does not necessarily qualify individual to evaluate research investigations. If a practicing agency really receives a large number of such proposals from the fields of psychology, psychiatry should have proportionate representation on the committees work to evaluate such proposals.

7. Grant awarding agencies should maintain a reasonable balance between, and a clear distinction between, funds for research and grants for service. Research funds should not be used to provide services, no matter how essential the services may be.

8. Service

Recommendations for Psychological Services

Canadian psychologists are convinced participating in prevention, diagnosis, treatment and rehabilitation services in the health field. A large part of their work brings them into contact with individuals suffering from emotional disturbance. As a result they have become alerted to serious gaps in our mental health program.

Canadian psychologists are convinced that services in the mental health field must be improved, and that they must be made available to all Canadians, so that to bring about improvements in psychological services in our mental health field have been proposed by a number of leaders including a national shortage of trained personnel and problems involved in retaining in these professional roles in provide services. Following the adoption of recommendations concerning service needs in

1. Need for Improved Services in the Mental Health Area

Any consideration of the health needs of Canadian citizens must give serious attention to the inadequacies existing in present services in the area of mental health. Future programs to assist Canadians with health care should include parallel assistance for the physically ill and for the mentally and emotionally disturbed.

2. Importance of Prevention and Rehabilitation

Care must be taken to make certain that adequate attention is given to preventive and rehabilitation services for both the physically and the emotionally handicapped. Unfortunately, in the field of mental health, these areas have been frequently neglected. This situation is wasteful in terms of both economics and human suffering.

3. Need for an Interdisciplinary Approach to Health Problems

Many professions and sciences are contributing to the health field today. This is true in the areas of both health services and health research. Service and research personnel are being drawn from a large number of backgrounds including medicine, the social sciences, the biological sciences and special education. It should be noted that many of the nonmedical scientists and professionals bring to the health field contributions which are based upon knowledge and research developments from within their own scientific disciplines. The terms "paramedical" or "ancillary" when applied to these health personnel are frequently inappropriate and misleading.

It is essential that the administrative

structure within health settings provide for genuine collaboration between medically trained personnel and staff whose training is in the nonmedical disciplines. Wherever possible, Ph.D. scientists and professionals from the nonmedical disciplines should be given responsibility and authority for planning and controlling the services which they offer and the research which they undertake.

4. Shortage of Trained Psychologists in the Mental Health Field

There is a serious shortage of trained psychologists entering the mental health field. Experienced staff are also being lost because of competition from other settings, including universities, business, and quite frequently, settings outside of Canada. A careful evaluation should be made of this situation to discover why some service settings are unable to compete for top-quality, fully qualified psychologists. Factors such as financial remuneration and professional opportunities and responsibilities within these settings should receive careful attention.

C. Academic Training

Recommendations Regarding Training Psychologists for the Health Field

A section of the accompanying report is concerned with the shortage of service and research psychologists in the health field. Most essential is the need for fully qualified Ph.D. psychologists, capable of undertaking supervision and leadership of subdoctoral psychologists in service settings. The availability of both doctoral and subdoctoral personnel will depend upon

The Mental Health Grants have played a most important role in enabling the universities to undertake the training of personnel for the mental health field. Following is a series of suggestions for improving the effectiveness of the Mental Health Grants in helping to meet the demand for psychologists in the mental health area:

1. Surveys should be made from time to time to assure that the amounts allocated to Mental Health Grants keep step with the increasing demand for mental health workers and with the number of good students seeking training for the mental health field.

2. The grants should be administered so as to encourage a reasonable number of psychologists to continue beyond the Master's degree to the Ph.D. Because the grants require a student to undertake to provide service to the province sponsoring his training, this would involve allowing the student to delay his commitment to the sponsoring province, until he has completed the Ph.D.

3. Some universities report that they are losing good students because announcement of the Mental Health Bursaries is not made until shortly before the student is scheduled to begin his studies. Most students make their academic plans before this time. As a result, many good students accept admission to other programs or even to universities outside of Canada where scholarship and fellowship awards are announced at an earlier date. It is strongly recommended, therefore, that a serious effort be made to process applications early and to announce the recipients of awards by March 31 of the year in which the student is to enrol for training.

4. It appears that, in some provinces, graduates who have received bursaries are extremely limited in the positions which they can take after graduation. The plan of requiring graduates to work for a stipulated period in mental health settings in the province which sponsored their training seems acceptable. Some provinces appear to have made the further requirement, however, that the graduate work only in institutions administered by the provincial government. This policy prevents the graduate from accepting employment in many excellent settings such as general hospitals and hospitals under the administration of the Department of Veterans' Affairs. Such restrictions on the professional freedom of graduates should be avoided whenever possible.

5. Some university programs offering training for the mental health field operate during the entire calendar year rather than the shorter academic year. Where this is the case, bursaries should be administered to cover the entire period in which the student is receiving training.

6. It is important that programs of financial assistance to students undertaking training for mental health positions not adopt too narrow a definition of training for the mental health area. Psychology must approach mental health problems from many perspectives. Since we do not yet know what is the "best" way to prepare a psychologist for mental health service, we must continue to work from the broad base of psychological science and allow considerable flexibility and variation in the training of workers for the field.

[illegible]

4. [illegible] Ir [illegible] [illegible]

graduates who have received technical or scientific training

[illegible]

appear to have been the result of conditions, but are also

the procedure work only in instances where [illegible] the

provincial government. This policy prevents the [illegible]

from accepting employment [illegible]

[illegible]

of the Department of Women's Affairs. Such [illegible]

on the professional training of graduates should be [illegible]

whenever possible.

5. [illegible] the university [illegible]

training for the medical health [illegible] [illegible] the

survive calamity year issues that the [illegible]

[illegible] this is the case, universities should [illegible]

to [illegible] the credit period or [illegible]

training.

6. [illegible] the Department [illegible] [illegible]

financial assistance to students [illegible]

medical health positions not [illegible] [illegible]

of training for the medical [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

THE CHAIRMAN: Thank you very much, Doctor Mailloux.

COMMISSIONER FIRESTONE: Doctor Mailloux, on page 2 in the last paragraph you say, and I quote: "Sponsoring agencies in Canada should give serious consideration to the likelihood of being faced with a larger share of the financial responsibility for Canadian research in the health area." I take it this sentence is related particularly to the need for doing more psychological research in Canada?

FATHER MAILLOUX: Definitely.

COMMISSIONER FIRESTONE: Now, sir, where is the money coming from now to pay for the research program that is going on, again in the psychological field?

FATHER MAILLOUX: I would say that it is difficult to answer with great precision this question at the present time.

COMMISSIONER FIRESTONE: Approximately would do.

FATHER MAILLOUX: Well, I must tell you that now a Committee is working on this particular problem, and you may have more specific information later, but what we must say now is that now probably a larger amount of money is coming for research in this country from United States sources than from Canadian sources, probably more than 50% of the money.

COMMISSIONER FIRESTONE: Do you know how much money we are spending on psychological research in Canada now?

FATHER MAILLOUX: I don't think we can

Doctor Mellinger.

Mellinger, on page 2 in the last paragraph you say, and I quote: "Research agencies in Canada should pay certain [illegible] in the health area." I take it this emphasis is [illegible] particularly to the needs for [illegible] psychological [illegible]

DOCTOR MELLINGER: Definitely.

Where is the money coming from now to pay for the research program that is going on, again in the psychological [illegible]

MEMBER MCINTOSH: I would say that it is difficult to answer with great precision this question at the present time.

CHAIRMAN STEWART: [illegible] would do.

DOCTOR MELLINGER: Well, I think that now a Committee is working on this particular problem and you may have more specific information later, but when we talk say now in that line probably a larger amount of money is coming for research in this country from United States sources than from Canadian sources, probably more than half of the money.

CHAIRMAN STEWART: Do you have any idea [illegible] we are [illegible] or psychological research [illegible]

answer this question at this present time. Again this will be supplied to you if you so wish later on, because there is another committee of the C.P.A. working on this.

COMMISSIONER FIRESTONE: Well, you see, Dr. Mailloux, we have a recommendation from you that we should spend more money on psychological research in Canada, with this money coming from Canadian agencies. It would help us a little if we knew when you are speaking of more money how much money, how is it going to be used, and where is it going to come from?

FATHER MAILLOUX: Unfortunately one couldn't answer this question. There is another committee working on it, but I think that the very fact that the larger part of research money is coming from abroad would justify this statement.

COMMISSIONER FIRESTONE: We are quite satisfied with the justification, but we would like to go one step further, sir. We are coming to you for advice, in order to offer advice to the Government of Canada we need to know certain basic facts on what the research program is at the moment, and where the money comes from, and what increase you would recommend to us to put forward to the Canadian Government if we agree with the views you have put forward.

Would it be possible for you to make available to us the information which these two committees of yours are working on, but following the assembly of this information we would require from you, if it is convenient for you and you are willing to give us some advice as to what your financial commitments you would recommend, the

total amount per annum, how it should be used, where it should go to, and how much of this money you feel is required should come from the Federal Government, because as you will appreciate, sir, we are called upon to advise the Federal Government and we are concerned to see what contribution the Federal Government can make to an overall program, and the share you expect the Federal Government to contribute. Could you offer this information and advice?

FATHER MAILLOUX: We would certainly be glad to do so, sir.

DR. MALMO: Well, I have two things to say, sir. In the first place, I think that you are perfectly right that we have to proceed on the basis of really adequate information, and that is the reason why our Executive appointed a separate committee to study this matter, and it is a matter which requires careful study, and I would say that it will take some time for this committee to work it out, so that I couldn't promise you a quick answer, but ultimately certainly this is the purpose of the committee.

The second thing I would call to your attention, sir, is that the statement is that, at the bottom of page 2 the request is that we consider the likelihood of being faced with a larger share of financial responsibility for Canadian research in the health field in the future, and this is based partly on the fact that we do know that much of our funds do come from the United States, and that we cannot go on counting on this, because in the event of budgetary difficulties the grants to foreign

countries would in all likelihood be cut before the domestic ones. This is the sort of reason that lay behind that statement.

COMMISSIONER FIRESTONE: Dr. Malmo, if I understand it correctly, your Association is making two points. One that the total amount available for research in the psychological area is inadequate, and secondly that a good portion, perhaps over half of that money is coming from other countries, namely the United States, and you would like to see(A),an increase in the total amount, and (B), be assured of the continuity of these funds if the monies that flow from the United States are reduced?

DR. DOUGLAS: We haven't made the statement that the amount presently available is inadequate. We don't want to make that statement until we see what is happening so far as our sources are concerned. At the moment I don't think we are prepared to say that there is not enough available for good research studies. We want to check this.

COMMISSIONER FIRESTONE: Well, maybe I didn't quite understand Dr. Mailloux then. Did I not understand that some young men had not been able to proceed with research programs because they had not been able to obtain the funds?

FATHER MAILLOUX: Yes, I think there is a good number of young people now who definitely cannot proceed, and I think also since you ask about how the money should be distributed, I think there is another important remark to make here.

We have in Canada a good number of

researchers, who are very well established with international reputations and so on, who would need to pursue their work on a quite sizable amount of money, and would need to be assured of continuity, and this is why we have lost for a number of years a good number of our best people in the field, because they could never be assured of that. The situation has improved, I might say, a little bit, but still it is a question year after year of trying to fill the gap and I think it is a most nebulous situation.

COMMISSIONER FIRESTONE: In other words, you say if I understand you correctly, that if there were increased funds for research in Canada we would retain many of these bright young people to do their research here and then practise when they completed it, is that a point you are making?

DR. DOUGLAS: Yes, we could keep our best people, have other people trained with them, and then these young people would be inclined to get the best of their training right here, instead of going abroad for long periods of time, and most of the time they remain there.

COMMISSIONER FIRESTONE: It would seem that you have been making rather a strong case that we do not have enough research funds available to achieve this objective at the present time, is that what you are saying?

FATHER MAILLOUX: Yes.

COMMISSIONER FIRESTONE: I don't want to get into the question of what extent the funds are adequate or inadequate. I am just concerned with the principle, and I would be quite happy to accept your

reputations and so on, who would need to [illegible] work or a more stable amount of money, and would need to be assured of continuity, and this is why we have had for a number of years a good number of our best people in the [illegible], because they could never be assured of that. The situation has improved, I hope so, a little but, but still it is a question year after year of trying to [illegible] the [illegible] and I think it is a most [illegible] situation.

COMMISSIONER MILLSBOUGH: In other words you say if I understand you correctly, that in those years increased funds for research in Canada or [illegible] many of these brilliant young people to go to other countries and then [illegible] when they go back it, as that point you are making.

DR. DOUGLAS: Yes, we found some of our people, have other people trained with them, and then these young people would be tempted to [illegible] of short training right here. Instead of going abroad for long periods of time, and most of the time they [illegible] there.

COMMISSIONER MILLSBOUGH: It would seem that you have been really [illegible] some that we do not have enough research funds available to achieve [illegible] objectives at the present time. Is that what you are [illegible]

DR. DOUGLAS: Yes.

[illegible]

to get into the [illegible] research the [illegible] journals or [illegible]. I am [illegible] with the [illegible], and I think we [illegible]

assurance, Dr. Malmo, that you make a supplementary report. One small point, you referred that it may take quite a bit of time until you get the reports of your committees. I take it, sir, that if we are to get the supplementary submission from you, we might expect it, say, in a period of several months, three or four months, rather than three or four years?

DR. MALMO: Yes, I think that is reasonable.

COMMISSIONER FIRESTONE: Because within that period it would be very useful to us, and we would hope to have your guidance before we make any recommendations to the Government. It would be much better substantiated.

DR. MALMO: I would certainly think it would be closer to the first time that you mentioned.

COMMISSIONER FIRESTONE: Should Canada develop a medical care insurance scheme that is comprehensive and applicable to all parts of Canada, should such a plan in your opinion include for medical services connected with mental ill health in addition to physical ill health?

FATHER MAILLOUX: I think that it is very hard for any one of us to answer this question on behalf of the Association, because definitely the Association has never given consideration to this. Of course, we have been rather new in this field, as you know, and we are not I don't think, in a position now to give really competent advice on such a problem. I wouldn't dare to do so.

[illegible] Mr. [illegible] a [illegible]

One small point, I'm referred that they take [illegible] a bit of time until you get the [illegible] your [illegible]. I take it, Mr. [illegible] that if we are to get the [illegible] submission from you, we might accept it, say, in a period of several months, three or four months, rather than [illegible] or [illegible] years?

[illegible] reasonable.

In that period it would be very helpful to us, as we would hope to have your [illegible] before we make any recommendations to the Government. It would be much better [illegible] treated.

Mr. [illegible]: I would certainly think it would be closer to the [illegible] time than [illegible].

Develop a radical [illegible] approach [illegible] a comprehensive and applicable to all [illegible] of [illegible]. Would [illegible] a place in your [illegible] for radical services [illegible] with [illegible] in addition to [illegible] health?

[illegible]: I think that is a very hard [illegible] any one of us to answer this question on behalf of the Academy [illegible]. Because [illegible] the Academy has never [illegible] to this. Of course, we have been [illegible] now in this [illegible] as you know, and we are not [illegible] think, in a position now to give really comprehensive advice on such a [illegible]. I wouldn't dare to

DR. DOUGLAS: I think your question was whether mental health services should be covered, not whether psychological services. I don't think there is much doubt in the replies we had from the members of our Association that the members feel very strongly that the needs of the people with mental health problems should be included. We also feel that many psychological services should be covered, but what we are not ready to say at this point is which ones.

COMMISSIONER FIRESTONE: That is a very helpful suggestion. I then gather that your Association would be in favour of having mental medical services included in the comprehensive program. Are you giving consideration to which areas of the psychological field should be included? Is that subject under discussion?

DR. DOUGLAS: This is the study that we are recommending that our Association now take under consideration. We have many ideas on this, but we are not yet ready to give a unified opinion on it.

FATHER MAILLOUX: Many times also I must mention that here psychological services may be connected with physical ailment as well, and in the field of rehabilitation they are physically handicapped, so I think in such circumstances it should be included as well.

COMMISSIONER FIRESTONE: Well now, just to bring this point to a conclusion, if you are giving some further consideration to this point, as to what type of psychological services should be covered, do you think you might come to some general understanding over the next three, four, five months, and such understanding if it

has been arrived at within that period be communicated to the Commission in connection with the other supplemental information you may make available to us.

FATHER MAILLOUX: Yes, I might at least mention here it is at the present time tax exempt. There is a great amount of inconsistency across Canada. It depends very much on the local officials and so on. Perhaps this should be clarified.

COMMISSIONER FIRESTONE: Do I understand this observation, Father, that this matter is still under consideration by your Association, and that you expect in the course of a number of months to come to some conclusion as to what areas you feel should be covered as part of mental health service. Is that under consideration?

FATHER MAILLOUX: Yes.

COMMISSIONER FIRESTONE: Would it be possible to say, that if you come to some conclusion in this field you will communicate that to the Commission.

DR. DOUGLAS: This is quite possible. I would expect we could answer this question within four to five months.

COMMISSIONER FIRESTONE: That is very helpful, and we appreciate the courtesy, your being willing to do a little extra work. It will help us a great deal. Thank you very much.

COMMISSIONER BALTZAN: I think we need you and your work now more than ever before, at least to be able to give a good definition of what can be considered normal as against all the evidence brought for those who are considered abnormal. I want to thank you for your

the Canadian is in [illegible] with [illegible]
[illegible] you any [illegible] to us.

[illegible]

at least [illegible] [illegible] the [illegible] [illegible]
There is a [illegible] of [illegible]
It depends very [illegible] on [illegible] and on [illegible]
[illegible] [illegible]

[illegible]

[illegible] [illegible] [illegible] [illegible]
expense in the [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible]
part of [illegible] [illegible] [illegible]

[illegible]

possible to say, [illegible] [illegible] [illegible]
this is [illegible] [illegible] [illegible]

[illegible]

I would [illegible] [illegible]
to [illegible] [illegible]

[illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible]

[illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

1 booklet that is there before you because it has brought me
2 up to date on the contemporary history in relation to this
3 problem. You have a word in there, I have forgotten, it
4 is something like opinicon. Before you go I want to look
5 this up. Just this question so I can get fairly integrated
6 into your problem. You stress basic research, and you
7 also -- that is within normal mental and emotional conditions,
8 you want more of that work conducted and conducted here.
9 You also want to have clinical research as a coincidental
10 project, and you want finally to try to help integrate the
11 psychologist within the mental, or shall we say the medical
12 team. Those three requirements in your submission, you
13 make a plea for those three things.
14 FATHER MAILLOUX: Yes.
15 COMMISSIONER BALTZAN: I presume I am
16 correct when I say the emphasis here, up to now has been
17 mainly on the academic work of the psychologist.
18 FATHER MAILLOUX: We are looking for
19 integration in both fields, of the services and research
20 setup because I think it is becoming more and more obvious
21 as we gather research data that to have research involves
22 many different factors. Just to give an example, for
23 instance, you have cultural pressure, that for instance may
24 force people to adopt certain diets, so even cultural
25 anthropologists may make a very great contribution but
26 it seems very important for us now. We can say as much for
27 social factors and what not, emotional factors and so on,
28 but what seems of importance to us now, of course, if we
29 develop our techniques, and now we have acquired a very
30 large amount of research device and so on, we should have

some policy to organize structure line-work along these lines, develop our own ideas, and the same thing I think applies in the field of applied psychology. There are many problems we often at times don't dare to tackle because it may appear to others it is outside the field, which it is not, because we are bound to present that kind of apprcach or attack a problem through this procedure because it is a major concern for us dealing with individuals we oftentimes don't consider as sick. We are involved in many colleges. We are dealing with adolescents who are going through very serious emotional crises. They may end up in psychosis, that sort of thing, also in the childrens' agencies or residential treatment agencies, juvenile delinquent agencies, we have to deal with it at this stage before they are ending up in a serious condition. Also in the field of rehabilitation we have to deal with a great many of these children and adolescents going back to society after having been in institutions, who were very maladjusted, afraid to meet people, don't want to go in the store to buy clothes. No one would consider them as psychotics or neurotics by general standards. There is a whole field there where a great amount of research is needed, and also service work.

COMMISSIONER BALTZAN: Applied psychology, as it stands today is a reality.

FATHER MAILLOUX: Definitely a reality.

COMMISSIONER BALTZAN: You want to see it in practice.

FATHER MAILLOUX: I would say here that

research in this particular area has certainly not adequately started in Canada.

COMMISSIONER BALTZAN: Thank you very much.

THE CHAIRMAN: Thank you Dr. Malmo, Dr. Douglas, Father Mailloux, Dr. Ferguson. We are grateful to you for this scholarly brief. In particular I think I may, on behalf of our research staff, thank you for the bibliography at the end of the brief, because it is going to be very helpful to them in pursuing the consideration of your submissions and in evaluating any subsequent information that you will be able to give to us. We would be very glad to have the additional information. We want to thank you for your assistance here today.

FATHER MAILLOUX: Thank you very much.

THE CHAIRMAN: We will rise now until nine o'clock tomorrow morning.

---Adjournment.

ROYAL COMMISSION ON HEALTH SERVICES

ENGLISH VERSION

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held at Montreal, Tuesday, 17th day of April, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. DAVID M. BALTZAN

Prof. O. J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

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Dr. ARTHUR F. VAN WART

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MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Mr. N. LAFRANCE

Proceedings of the hearing held
at Montreal, Tuesday, 17th
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Miss ALICE GIRARD, R.N.

Dr. DAVID A. GALZAS

Prof. C. J. THOMPSON

Mr. [illegible] MACINTOSH, Q.C.

Dr. ARTHUR F. VAN NAMT

COMMISSIONER COURSOL:

Mr. R. N. HAIG, Q.C.

LITIGATION OF RTS ARTS.

SECRETARY:

Mr. R. LAFRANCE

ANGUS. STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Montreal, P.Q.
Tuesday,
April 17, 1962.

--- On commencing at 9.00 a.m.

THE CHAIRMAN: Monsieur Larue, I believe you have a brief to submit?

SUBMISSION OF

MR. J. P. LARUE

Appearances:

Mr. J. P. Larue,

Mrs. J. P. Larue,

Dr. C. Houle

MR. LARUE: Mr. Chairman, gentlemen and ladies, I have the honour to submit to you the following brief. I didn't feel it necessary to submit a brief to your Commission in view of the fact that my ideas on health insurance were not in conformity with the statements given by the groups with which your Commission has consulted.

I am connected from the first of March, 1934 to the 7th of June, 1937 with this plan, and it was recognized as a complete success. I realize therefore that in order for a valid opinion, we must have complete studies on this matter, taken over several years. I can also have an opinion, which is not only a theoretical one, but is based on three years of actual experience. I am therefore the only Canadian to have such experience as the Blue Cross. This gives me an incontestable right

-- Ok commencing at 7 00 a.m.

MRS GUILFORD: Mornington Lewis, I believe you have a letter to submit?

Mr. G. F. Lewis.

In. G. Moore

and letter. I now the honour to submit to you the following brief. I think it is necessary to submit a brief to your Commission in view of the fact that no issues on behalf of the Crown have not in controversy with the shareholders since it was when which your Commission is a course.

I am connected from the first of March, 1938 to the 7th of June, 1947 with the firm, and I was recognised as a responsible officer. I mention this in order to show for a valid opinion, we must have certain knowledge of the matter, which over several years. I can also have an opinion, which is not only a technical one, but is based on three years of actual experience. I am hoping to be the only fortunate to have some experience in the film trade. Then please be so kind enough to

of considering myself a pioneer of health insurance in Canada.

In 1957, after I had conducted my experiment, I began a seven-month study in order to finalize an insurance plan, in order to publicize this plan, which was recognized as an ideal health insurance plan, which meets in all points the way of life of our country, I then submitted a copy of this plan to the Junior and Senior Chambers of Commerce, and many other associations and unions. The latter submitted this plan in turn to the Ministry of Health, without any further consideration. I therefore considered my plan would not be considered by the governments.

I proposed in my plan the elimination of private mutual and commercial insurance companies, as well as the Department of Health Insurance, including the companies that are organized for life insurance. I proposed the following programme. That a national organization should be set up by the Federal Government, but administrated by the Provincial Government. The family contributions would be collected by the Federal Government and distributed on a pro-rata basis to the Provincial Governments.

As I stated in my plan, the contribution of each family would be $3.70 per week, and the contribution of the employees would be met by an equal contribution. All families would have the right to medical services, including visits to the doctor, as well as visits by the doctor to the homes of the patients. It would also include maternity cases and psychiatrists,

of [illegible] a [illegible] of health [illegible] in Canada.

[illegible] had occurred [illegible] experiment, I began a [illegible] work along in [illegible] Thereby an insurance plan, in order to [illegible] the plan, which was recognized as an ideal health insurance plan, which meets in all points the way of life of our country. I then submitted a copy of this plan to the Dominion and Provincial Governments of Canada, and many other associations and [illegible]. The letter [illegible] was given to the Ministry of Health, without any further consideration. I therefore considered my plan could not be considered by the government.

I proposed in my plan [illegible] of [illegible] private [illegible] and commercial insurance companies, as well as the Department of Health Insurance, including the companies that are organized for life insurance. I proposed the following programme. That a national organization should be set up in the Federal Government, but administered by the Provincial Governments. The family contributions would be collected by the Federal Government and distributed on a [illegible] basis to the Provincial Governments.

As I stated in my plan, the contribution of each family would be $3.00 per week, and the contribution of the employees would be one to [illegible] contribution. All [illegible] would have the right to medical services, including [illegible] to the [illegible], as well as visits to the doctor in the home of the insured. It would [illegible] [illegible]

denists, etcetera, and surgical operations, and the services of the anaesthetist, and laboratory services, operation room fees, etcetera. The rates for these services would be established after an agreement between the organization of health and the college of each professional group, as well as the association of hospitals in each province.

A table is attached to my plan, which gives the result of the revenues and the expenditures which are based on the year 1961. The income from this plan would be in the order of 919 million dollars, and the expenditures in the order of 570 million dollars. The surplus would be granted to support the family of the hospitalized person.

This proposal should be accepted because it is based on a democratic principle, namely, government of the people by the people. This principle has often been proclaimed by our country, but we have other influences. The insurance companies would be one of the major influences in blocking this democratic method.

It is quite evident that if my programme were adopted it would meet the entire needs of the population of the country. Within a short time it would meet all the needs of the country. It would be within the means of all citizens, who would find perfect tranquillity and reassurance, and would no longer be haunted by the fear of a terrible illness for which he would be ill prepared. He would know by that time that all his property and savings would be free from all of the menaces that hovered over them.

dentists, doctors, and surgical operations, and the services of the orthodontist, and laboratory services, operation room fees, anesthesia. The medical benefit services would be established after an agreement between the organization of health and the college of each professional group, as well as the associations of hospitals in each province.

A table is attached to my plan which gives the result of the research and the experiments which are based on the year 1971. The income from this plan would be in the order of 900 million dollars, and the expenditures in the order of 870 million dollars. The surplus would be granted to support the family or the pensioner.

This programme should be accepted because it is based on a democratic principle, namely, government of the people by the people. This principle has often been proclaimed by our country, and in many other influences. The Canadian Commission would be one of the major influences in choosing this democratic method.

It is quite evident that if my programme were adopted it would cost more money than at the population of the country. Without a doubt it would meet all the needs of the country. It would be within the means of all citizens, and would find permanent tranquility and contentment, and would be honest to remove by the hour of a terrible illness for which in vain be all programs. He would enjoy by that time the all his property and savings and, he also from all to the memories that injured our, then.

Governments are responsible for the health of the country. However, governments do delegate powers to certain groups. We know that it is the immediate task of government to meet the desire of the entire population, and to do this even to the detriment of certain private interests.

Well, a great deal of discussion has been held on this subject of hospital insurance in the Federal and Provincial Governments. What is the result? The result is that there have been gaps, and there should be amendments made to these plans. Perhaps it would have been more logical if the Ministers of Health had consulted experienced people on these steps.

In 1957 I sent the Ministry of Health my plan, and never received a reply. I did this again. I also offered my services to the Chairman of your Commission, and he replied that the appointment of Commissioners was the duty of the Cabinet. It was therefore considered right to appoint a certain nurse, Miss Girard, to represent our province.

I even asked the Minister of Health of Quebec to allow me to submit my plan to actuaries of the Department of Insurance to show my plan would ensure the well-being of all citizens of our country, and also assist the government by making certain savings.

I have facts and experience at my disposal to prove that this plan is practical and would be in the interests of the general public. The government would be freed from a certain physical burden, and would be free also from the obligation of floating loans, which

Government is one necessity for the
health of the country. "Moral" measures to delegate
powers to certain groups. We have not the
immediate task of governing, to meet the change of the
entire population, and to do, not even be the instrument
of certain private interests.

With a great deal of discussion, but less
heat of this subject of hospital, I turn to the national
and provincial governments. What is the reality? The
result is that there have been gaps, and there should
be and become more to fill them. Perhaps it would
have been more logical if the Ministers of Health and
Welfare concentrated people on these areas.

In 1947 I went out with two of my colleagues
my idea, and never received a reply. I did hear that
I also offered my services to the Ministry of Health
Communication, and to explain that the Government
Commissioners was the duty of the Ministry. It is
therefore considered right to develop a central Bureau,
from a [illegible]

I also asked the Minister of Health of
Ontario, to allow me to have my plan on exhibition on
the main front of Parliament to have my own [illegible]
the well-being of all citizens of our country, and also
assist the Government by making constructive [illegible]

I have been not unknown to the Government
to know that this can be provided and would be in the
interests of the general public. The Government would
be [illegible] from a certain [illegible], and also on

would amount to long-term interest.

I have never resorted to political interests, but it being considered opportune to appoint a Royal Commission which will, in my opinion, only issue diverse opinions ----

THE CHAIRMAN: Mr. Larue ----

MR. LARUE: Certain people will say that this is socialism. Well, this is an easy way to reject valid opinions, but why don't we call it Christian socialism, provided that the taxpayers will receive their rightful return.

Others will say that this amounts to nationalized medicine, but this is not true, because the doctors will not be submitted to any salary system.

As a conclusion to this submission, I should like to submit to you now a copy of my plan.

THE CHAIRMAN: Mr. Larue, we thank you for your brief. You said that the rate for each family will be $3.70 per week?

MR. LARUE: This means one dollar for each citizen of Canada. The rate for each family in Canada would be $3.70.

THE CHAIRMAN: Well, the figure of $3.70, is this what would be paid by the government?

MR. LARUE: No, the government would not pay anything. It would not have anything to spend. The total would amount to 991 millions per year. The excess money would be used to make family payments to the family of the sick person.

THE CHAIRMAN: And what about families

that cannot pay?

MR. LARUE: Well then, the premium would be paid by the public organizations in each province.

THE CHAIRMAN: How can you identify these persons?

MR. LARUE: Well, there are needy cases. There are the unemployed, we know who they are, those who are unable to pay their contributions. These contributions will be paid by the government, by the provincial government.

COMMISSIONER GIRARD: Mr. Larue, how can you decide, and by what study could you ascertain who is entitled to receive free insurance without paying premiums?

MR. LARUE: Well, it should be the Federal Government. Well, among the needy cases there are those people who benefit from social security. Those who have families, dependants. In Quebec we know there are families with fifteen children. It is the case with my wife. Perhaps the expense would be too high. In this case public welfare organizations would pay part or all of the contributions.

COMMISSIONER GIRARD: Well, you have to have a certain scale. For example, will this apply to people who have fifteen children, or have five children? You have to have a certain criterion.

MR. LARUE: Well, everything would depend on the income.

COMMISSIONER GIRARD: You know the government has many people to discuss such studies.

MR. [illegible]: Well then, the premium would be paid by the public organizations in each province.

MR. O'[illegible]: How can you [illegible] these persons?

MR. [illegible]: Well, there are ready cases. There are the unemployed, we know who they are, those who are unable to pay their contributions. These contributions would be paid by the government, by the provincial government.

COMMISSIONER FRAND: Mr. Lemoe, how can you decide, and by what study could you assert to who is entitled to receive free insurance without payment premiums?

MR. [illegible]: Well, it would be the federal Government. Well, among the needy cases there are those people who benefit from social security. Those who have families, dependents. In cases we know there are families with fifteen children. It is the case with my wife. Perhaps the expense would be too high. In this case public or private organizations would pay part or all of the contributions.

COMMISSIONER FRAND: Well, you have to have a central, [illegible]. For example, will this apply to people who have fifteen children, or have five children but have to have a certain contribution.

MR. [illegible]: Well, everything would depend on the income.

COMMISSIONER FRAND: You know the government has very people to discuss such things

This would be one of the criteria you would use, the family income. Well, what family income in your opinion is required in order for the family to receive assistance from the State?

MR. LARUE: Well, they would conduct a survey at home. You can conduct a survey as to the income and the dependents fees, existing in each family.

COMMISSIONER GIRARD: But do you have any idea as to the income which would serve as a demarcation point? That is, a critical income? Does your plan provide for a certain income which would prove to be inadequate to provide for the payment of this insurance?

MR. LARUE: Well, the people who would be sent out would decide whether the family would be able to pay.

COMMISSIONER GIRARD: Well, is this decision left up to the government?

MR. LARUE: Yes, it is left up to the public welfare organization of the province.

COMMISSIONER GIRARD: In your plan, sir, did you calculate how many people would be below the critical income level, and would have to have their premium paid by the government?

MR. LARUE: Well, unemployment is pretty high we know.

COMMISSIONER GIRARD: Well, how will you establish what the plan will cost if you don't know how many people will be able to contribute to this plan?

MR. LARUE: Well, the plan will be financed partly by provincial capital. The figures given

in my plan are based on past experience.

THE CHAIRMAN: Mr. Larue, you submitted a copy of your plan to Mr. Lafrance?

MR. LARUE: Yes.

THE CHAIRMAN: Copies will be distributed to each Commissioner and your plan will be studied, of course, with the other submissions which we have received.

COMMISSIONER GIRARD: Mr. Larue, as the Chairman has just stated, you submitted one copy of your plan, but the other Commissioners have not received copies, therefore we were unable to study your plan. Generally we receive briefs two days in advance, so that each Commissioner will have the opportunity to study them. Unfortunately, this is a very detailed plan, so that you will understand we were unable to study it.

THE CHAIRMAN: Each Commissioner will have a copy of your plan?

MR. LARUE: I can give you some explanations now.

In paragraph 20, in my opinion, the opinions expressed before the Royal Commission will be divergent, and will have no basis. I say this because the Associations which have submitted briefs, these briefs have been studied and based on their own particular interests, whereas this brief is based on the interests of the public.

THE CHAIRMAN: Well, the Commissioners will decide whether or not this is in the public interest.

MR. LARUE: Well, of course, it is my own opinion.

my plan are based on past experience.

a copy of your plan to Mr. Lundeen?

Mr. Lundeen: Yes.

THE CHAIRMAN: Copies will be handed out to each Commissioner and your plan will be studied, of course, with the other submissions which we have received.

COMMISSIONER GOULD: Mr. Lundeen, as the Chairman has just stated, you submitted one copy of your plan, but the other Commissioners have not received copies. Therefore we were unable to study your plan. Generally we receive briefs two days in advance, so that each Commissioner will have the opportunity to study them. Unfortunately, this is a very complicated plan, so that you will understand we were unable to study it.

have a copy of your plan?

Mr. LUNDEN: I can give you some explanations now.

Mr. Chairman and, in my opinion, the Commissioners appointed under the Royal Commission will be disappointed, and will have no doubts. I say that because the Commissioners which have submitted briefs, some briefs have been prepared and based on their own methods of thinking. Therefore this brief is based on the experience of our problem.

THE CHAIRMAN: Well, the Commissioners will determine for out this in the public hearings.

Mr. LUNDEN: Well, of course, it is a

THE CHAIRMAN: We will respect your opinion, of course, and I thank you very much, Mr. Larue, and Dr. Houle, do you have anything to say?

DR. HOULE: As to the reference to chiropractors in the plan, I appreciate ---

THE CHAIRMAN: You will appreciate that we are going to have representations from the Chiropractic Association?

DR. HOULE: Well, I am sorry to say this, in view of Mr. Lesage's withdrawal of the Commission on the grounds that the programme is strictly on a Federal basis, the Association of Chiropractors have thought it not proper to make a submission, and therefore, if there is no further question I will have to let it go.

THE CHAIRMAN: If your Association made a decision not to present a brief, naturally we respect that decision, as we did the decision Mr. Lesage took on constitutional grounds. If the decision of the Chiropractors' Association was made on policy grounds, it is a decision for which you must accept responsibility. I don't think we can take a submission from the Chiropractors through the side door. If they wish to make a submission, we should be very glad to hear them.

DR. HOULE: I quite agree with you on that.

--- EXHIBIT NO. 233: Submission of Mr. J. P. Larue.

THE CHAIRMAN: Now, we will have the

submission from the Catholic Hospital Association of Canada.

THE CHAIRMAN: This will be exhibit 234.

Mother Dorais, I believe you are going to open the discussion.

--- EXHIBIT NO. 234: Submission of the Catholic Hospital Association of Canada.

SUBMISSION BY

THE CATHOLIC HOSPITAL ASSOCIATION OF CANADA

Appearances:

President	Mother M. Berthe Dorais, G.N.M., Montreal, Quebec
Chairman	Most Reverend Alexander Carter, North Bay, Ontario.
Past President	Reverend Raymond Durocher, O.M.I., Winnipeg, Manitoba
First Vice-President	Sister Mary Clarissa, C.S.M. Antigonish, Nova Scotia.
Secretary	Sister Mary Patricia, S.S.J. Port Arthur, Ontario.
Treasurer	Sister Marie Joseph, S.G.C. Ottawa, Ontario.
Member	Doctor Paul Bourgeois Montreal, Quebec
Director	Reverend Lorenzo Danis, O.M.I. Ottawa, Ontario.
Chairman	Sister M. Felicitas, S.P. Montreal, Quebec
First Vice-President	Sister Marion, S.S.J. Toronto, Ontario
Past Chairman	Sister Denise Lefebvre, G.N.M. Montreal, Quebec.
	Soeur Francoise de Chautot

Canada.

[illegible] Commissioner [illegible] 22d.

Member [illegible]

to open the Convention.

--- RESOLUTION NO. 23:- Commission of the Canadian Council Association of Canada.

ADMISSION BY

President	Mother M. Bernie Morris, C.N.D., Montreal, Quebec
Chairman	Mont Bernardo Alexander Centre, [illegible]
	Winnipeg, Manitoba
Secretary	Sister Mary Patricia, S.S.J., Sault Ste. Marie, Ontario.
Treasurer	Sister Marie Joseph, S.J., Sudbury, Ontario.
	Washington, Urban
Director	Reverend Clement Tembe, C.S.C., [illegible]
Auditor	Louise H. Patterson, S.F. [illegible]
Place of Meeting	Sister [illegible], S.S.J. Toronto, Ontario
Place Chairman	Sister Marie Lefebvre, C.S.J.
	Sister [illegible] de Chantal

MOTHER DORAIS: Mr. Chairman, I am pleased to introduce the members of our delegation. For the Administrative Board, the Most Reverent Alexander Carter, North Bay, Ontario. For the Board of Directors, Sister Marie Clarissa, First Vice-President; Sister Mary Patricia, Secretary; Sister Marie Joseph, Treasurer; Doctor Paul Bourgeois, a member; Reverend Lorenzo Danis, Director; and Reverent Raymond Durocher, past President. For the Canadian Conference of Catholic Schools of Nursing, Sister M. Felicitas, Chairman; Sister Marion, First Vice-Chairman; Sister Denise Lefebvre, past President; Councillor, Soeur Francoise de Chautot

THE CHAIRMAN: We welcome your distinguished delegation.

MOTHER DORAIS: Mr. Chairman and Members of the Royal Commission on Health Services:

We would like to thank you for the opportunity of appearing before you and presenting for your consideration a brief from the Catholic Hospital Association of Canada. Associated with us in this presentation is the Canadian Conference of Catholic Schools of Nursing.

The Catholic Hospital Association of Canada is a Federation of the Catholic Hospital Conferences of the different provinces. The Canadian Conference of Catholic Schools of Nursing is directly responsible to the Catholic Hospital Association of Canada.

We attempt, in our brief, to demonstrate the historical role of the Catholic Hospitals of Canada and to show how closely linked it is with the earliest

history of Canada.

We point out the reason for the existence of Catholic Hospitals by indicating the salient features of their philosophy. This philosophy endows them with special characteristics, which we feel, justify their continued existence as a separate entity, while co-operating closely with other hospitals, with the communities in which they are located and with the various levels of Government.

I. THE ESSENTIAL CHARACTERISTICS OF CATHOLIC HOSPITALS TO BE SAFEGUARDED.

The availability of Hospital Insurance to the people of Canada has changed the financial relation of the hospitals with the people, without, however, changing the essential characteristics of our Catholic hospitals.

Recommendation 1

> We respectfully recommend to the Commission that they urge the Federal Government to safeguard in every way possible the essential character of the Catholic hospitals.

We point out in particular the vital role which the presence of a chapel and the availability of a Chaplain play in our very existence. But because these have budgetary implications we recommend to the Commission that where Provincial Governments do not approve as operating expenditures Chaplain's salaries, or where funds are not available for the construction of Catholic chapels, the Government ensure that some

source of revenue be left available to the voluntary institutions in order that these essential elements of their character be preserved.

II COOPERATION BETWEEN HOSPITALS, LOCAL COMMUNITIES AND GOVERNMENTS TO ENSURE ADEQUATE STANDARD OF CARE

We would like to stress our belief that the successful operation of our hospitals depends on agreements arrived at in a true spirit of partnership between the hospital, the local community and all levels of government. This necessitates extensive consultation between all parties involved.

Recommendation 2

That the Federal Government ensure in its agreements with Provinces and in its acceptance of the plans of administration as submitted by them, the availability to the individual hospitals of adequate payments for the provision of an adequate standard of patient care.

III PROVISION FOR SOUND FINANCIAL STABILITY TO ASSURE THE CONTINUATION AND DEVELOPMENT OF CATHOLIC HOSPITALS

To illustrate the present status of the Catholic hospitals, we point out that of some 87,803 general hospital beds in the country, 35,149 or approximately 40%, are owned by Religious Orders. In terms of capital, these beds and equipment were valued in 1958 at approximately $350,000,000. It is difficult to imagine the implementation of Universal Hospital Insurance in Canada were these beds not available.

[illegible] of [illegible] in [illegible] to [illegible] institutions [illegible] [illegible] of [illegible] [illegible].

II [illegible]

[illegible]

It seems [illegible] to [illegible] that the successful operation of [illegible] depends on [illegible] [illegible] at [illegible] [illegible] or [illegible] between the [illegible], the local community and all levels of government. [illegible] [illegible] community [illegible] [illegible] all [illegible] involved.

[illegible]

That the Federal government [illegible] in its arrangements with [illegible] [illegible] to the acceptance of the plans of [illegible] as submitted by them, the availability to the individual [illegible] of [illegible] [illegible] for the provision of an adequate [illegible] of [illegible] [illegible].

III [illegible]

[illegible] the present [illegible] of the [illegible] hospital [illegible] in the country, [illegible] approximately [illegible], are owned or [illegible] [illegible]. In terms of capital [illegible] [illegible] [illegible] are valued in [illegible] at approximately $[illegible]. It is difficult to imagine the [illegible] of this [illegible] hospital [illegible] in [illegible] [illegible] [illegible] available.

Dorais

We draw the Commission's attention to some of the difficulties resulting from the implementation of the various Dominion-Provincial agreements for the provision of hospital insurance. We wish particularly to record the omission in the "Hospital Insurance and Diagnostic Services Act" of recognition of interest on capital and short term loans, and of depreciation of buildings and physical plant, as a real cost of operation.

However, pending a satisfactory solution to this problem, we continue our ownership and operation of hospitals in a spirit of true partnership with the communities in which they are located and with all levels of Government.

Recommendation 3

> That the Royal Commission on Health Services urge the Federal Government to establish a "Bill of Rights" for those non-profit institutions under private ownership, in order to produce in those institutions the sense of security and serenity so necessary for their continuation, development and effectiveness.
>
> We also recommend the revision of the "Hospital Insurance and Diagnostic Services Act" to secure recognition of depreciation of buildings and physical plant, and of interest on capital and short term loans, as a shareable cost of operation.

Dorais

IV RECOGNITION OF CATHOLIC NURSING EDUCATION AT ALL LEVELS

a) Continued recognition of a Diploma Program of Nursing.

We are convinced that the future of the diploma program will depend entirely on the manner in which the schools are prepared to meet the challenge of improved nursing education in the immediate future. We recognize the complexity and disadvantages of providing education and, at the same time, exacting service in payment for this education. One advantage of the independent school is the ability to regulate the amount of service to be provided by the student nurse according to her educational needs.

Recommendation 4

That adequate financial assistance be provided to schools of nursing, not only to maintain their present status, but to make much-needed improvements in the immediate future;

That such financial support provide for adequate salaries to employ and retain the required number of qualified nursing educators (administrative, supervisory and teaching);

That because of their past valuable contribution in all fields of nursing, the Sisterhoods be given an opportunity to devote themselves to all forms of existing programs and to participate in the planning

We are convinced that the Jewish religious program will emerge, on the manner in which the community is prepared to meet the challenge of the over-riding circumstances in the immediate future. It recognizes the complexity and diversity of problems concerned, and, at the same time, concentrates energies in powerful education. One advantage of this development seems is the ability to regulate the amount of services to be provided by the amount some according to educational means.

Most necessary financial readjustments provided to schools of necessity, not only to maintain their present existence, but to make good unmet commitments in the immediate future

That some financial support provide for adequate salaries to employ and retain the required number of qualified teaching educators (administrative, supervisory and instructional)

That because of their past contribution in all fields of human, the aforementioned is given a responsibility to assist institutions to meet, if possible, programs and to participate in the planning

Dorais

and execution of new programs;

That whatever may be the future system of financing for nursing education, provision be made for Catholic Schools of Nursing to receive the same consideration as other schools of nursing. This has also been strongly recommended by the Canadian Nurses' Association.

b) Recognition and subsidization of Degree Programs

Degree programs are conducted by universities or affiliated colleges. Their aim is to prepare nurses for leadership positions including teaching, supervision, administration and public health.

Because of the need for a larger number of nurses with such preparation for teaching and supervisory positions, we support the degree programs and urge their expansion. We further support the recommendation of the Canadian Nurses' Association and the Canadian Conference of University Schools of Nursing in their requests for financial assistance for such programs, for the preparation of their teaching personnel and for bursaries and loans to students enrolled in them at all levels.

Recommendation 5

That the contribution of Catholic Universities and Colleges in this field be recognized and encouraged by such financial help as is necessary to strengthen the present programs, and that such facilities

[illegible] may be [illegible] from [illegible] financial for [illegible] education, provision be made for [illegible] to receive due consideration in other models of [illegible]. This has also been strongly recommended by the Canadian Bureau of Statistics.

[illegible] colleges. There [illegible] to [illegible] boarding, supervision, [illegible] and [illegible] [illegible].

Because of the need for a larger number of nurses who have [illegible] for boarding and supervisory positions, we support the [illegible] and urge their [illegible]. We further support the recommendations of the Canadian Bureau of Statistics and the Canadian Conference of University Schools of Nursing in their requests for financial assistance for [illegible] programs, for the preparation of their teaching, [illegible] and for bursaries. Loans to students should be kept at all levels.

Recommendation 3

That the establishment of degree-granting universities and colleges in Nova Scotia be encouraged and encouraged by each financially [illegible] is necessary to strengthen the present programs, and that such facilities

be extended to the areas of the country where they are now non-existent, so that such advanced education under Catholic auspices be available for those desiring it.

c) Right of training Nursing Assistants

In some provinces nursing assistants are prepared either in hospitals or in vocational schools. In others, these courses are restricted to vocational schools only. In the latter case it is impossible for candidates, who might so desire, to secure their preparation under Catholic auspices.

Recommendation 6

That provision be made in each province for the education, under Catholic auspices, of nursing assistants for those who wish to avail themselves of such education.

d) Availability of bursaries for preparation of qualified Nursing Personnel.

We recognize the need for well-qualified nursing personnel for various positions at all levels of responsibility in hospitals and schools, and for financial help for nurses preparing for such positions.

Recommendation 7

That financial support in the form of bursaries adequate in number and amount, leaves of absence with pay, etc., be made available by the Government to prepare urgently needed personnel for:

1) specialized nursing care; 2) administration and supervision of nursing service; 3) teaching in hospital and other basic schools of nursing; 4) teaching in College and University nursing programs.

e) Institution of research programs in the nursing field

The Catholic Hospital Association of Canada recognizes that the continuous acquisition of knowledge is essential to a profession serving a dynamic society.

Recommendation 8

That research and experimentation be carried on 1) in relation to patient care 2) in relation to administration of nursing service 3) in nursing education.

CONCLUSIONS

We would ask the Federal Government to recognize the necessity of the Catholic Hospitals in our Canadian culture. We stress the vital importance for Catholic hospitals to receive such financial assistance as will enable them to give a standard of patient care and a quality of education in keeping with their tradition of work in the Canadian health field, without suffering invidious comparison with publicly owned institutions.

We again thank the Honourable Chairman and Members of the Commission for their hearing of our submission. We are prepared to answer questions directed to us within the limit of our competence.

THE CHAIRMAN: Thank you very much. I think we will have some questions to put. I don't think we will doubt your competence. You may doubt the competence of some of the relevance of the questions, that kind of thing. I suppose it is a fact that hospitals, some hospitals under Catholic auspices are devoted to the care of mentally ill.

MOTHER DORAIS: Yes, Mr. Chairman. We have a number of them in the Province of Quebec.

THE CHAIRMAN: Have you any views to express as to whether such hospitals, the operating cost of such hospitals should be brought under the Hospitalization and Diagnostic Services Act?

MOTHER DORAIS: We feel that this matter has not been cleared with our directors, but personally speaking I would say, Mr. Chairman, that we feel it should be brought under the Hospital Services and Diagnostic Act, because of the close integration of care of these patients and the care of such patients that may be admitted to general hospitals.

THE CHAIRMAN: We have received recommendations from one end of the country to the other that this be done, and we are anxious to know what the views, what your views are, representing as you do, such a large segment of the hospital field in Canada.

MOTHER DORAIS: I might, with your permission, Mr. Chairman, have Father Durocher comment on this.

FATHER DUROCHER: I feel it is kind of a discrimination at the present time, not kind of

discrimination, but it is discrimination against this particular kind of sick person, and those who take care of him. I would include, of course, the people who have tuberculosis, that were deliberately excluded, most likely, because they are very long term care situations, but this is precisely the kind that cost a lot of money and which take up a lot of provincial funds which might prevent the provincial government from doing what they are actually doing for the acute care hospitals. There is a very direct connection between Federal participation in the hospitalization plans and the expansion of these plans and the care of the mentally ill and tubercular patients in the sense it does affect the amount of money the provinces can allocate to health in general. If they got more money for the tubercular and mentally ill they would have more money available for other kinds of health care. We, I think, as Catholic institutions, are perhaps more and more concerned because, at least, the trend in Western Canada, that I have seen, is that the Sisters in shifting over from certain kinds of care that are less required now are being asked to go more and more into the field of long term chronic and mentally ill care. In that sense we will be more and more concerned with the problem. Does that satisfy?

THE CHAIRMAN: It is not a matter of satisfying, Father Durocher, it is a matter of having an expression of opinion of an organization such as yours that are competent to put forward considered views.

FATHER DUROCHER: I think, no doubt, Mr. Chairman, in all parts of Canada, if the present plan

discrimination, but it is a discrimination against the
particular kind of sick person, and there [illegible]
of them. I would think, of course, the people who have
tuberculosis, that were definitely contagious, [illegible]
because they are very long term cases and [illegible]
is precisely the thing that costs a lot of money and [illegible]
take up a lot of provincial funds which might [illegible]
the provincial government from doing what they are [illegible]
doing for the acute care hospitals. There is a very
direct connection between financial restriction [illegible]
rehabilitation plans and the expansion of these [illegible]
and the care of the mentally ill and tuberculosis patients.
In the sense it does affect the amount of money the
provinces can allocate to health in general. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible] even [illegible] kinds of [illegible] that are least
required now are being moved to no longer [illegible] more [illegible] the
field of [illegible] and mental [illegible]. In
that sense [illegible] more [illegible] with the
problem. Does that satisfy?

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

of Federal assistance for hospitalization is continued that our institutions will be willing to accept and encourage the expansion of the plan to these institutions, mentally ill and others.

THE CHAIRMAN: Advertent to recommendation three on top of page 4, where you ask, in fact, for a Bill of Rights in connection with the religiously based hospitals. Does your association foresee or fear that from the trend of things as developed under the Hospitalization and Diagnostic Service Act that there is any impediment to the expansion of the religiously based hospital?

MOTHER DORAIS: Mr. Chairman, in order that there be no misunderstanding as to the stand we take on this particular area of the problem, I would like to ask His Excellancy, Bishop Carter to tell us exactly the position, the Catholic position concerning voluntary institutions in our Canadian Society. From thereon I would, with your permission, continue to explore the question that you have asked.

BISHOP CARTER: Mr. Chairman, I think that we have to, perhaps, lay down one or two principles before we can come to a direct answer of your question as to whether or not the actual existence of our Catholic hospitals is being endangered.

In the brief itself, and I am not going to dilate on this point, we have the reasons for the Catholic hospitals existence. I think we have to make one or two points clear.

Financially the Sisters would be very well

that our institutions will [illegible] to attempt [illegible] courage the [illegible] these [illegible], mentally ill and others.

THE [illegible]: [illegible] tion three on top of page [illegible], a bill of Rights in [illegible] hospitals. Does your [illegible] from the [illegible] as developed under the hospitalization and [illegible] service [illegible] is an impediment to the [illegible] of the [illegible].

[illegible]: [illegible], Chairman, [illegible] that there be no [illegible] as [illegible] on this particular area of the problem, I would like to ask [illegible]

[illegible]

institutions [illegible] would, with your [illegible] question that [illegible].

[illegible] that we have [illegible] principle before we can [illegible] our [illegible] hospitals [illegible].

In the [illegible], and I [illegible] dilate on this [illegible] hospital [illegible] point [illegible].

[illegible]

advised to get out of the hospital field completely. If the communities could recouperate that part of the $350 million that is represented by their holdings, they would be in a very sound financial position to carry on their other activities and their charities. They could then hire themselves out as nurses at a salary, and that money would also accumulate to the community. The present situation as it exists today is imposing a tremendous burden upon the religious communities because they have to meet their capital loan and debt, amortisement and depreciation, and yet the budget set-up for them by the provincial governments is exactly the operating budget. Where do they find that money?

From a purely financial, pure business, pure human point of view they would be well advised to get out of the hospital field completely. That brings up the other point, why don't they get out. It is precisely because we don't want to abandon the care of the sick as part of the church activity. If you go back in history you will find the care of the sick was originally completely, unanimously, entirely a religious preoccupation, and hospitals stemmed from the church. I would say for us, as good citizens, we should be very ill advised to allow the hospitals to go completely into the practical, pragmatic and materialistic control of governments. I don't talk now for the Catholic church, but all religions. If we go, there will be something gone from the hospital field that will never be replaced. You don't know and I don't know when the time may come that governments may change and more socialism be

1 increased, with the result that hospitals will become
2 nothing more than the exercise of authority, and we may
3 be faced with some very grave problems in our whole
4 attitude toward illness and towards the right of people
5 to live after they are ill. These are things we don't
6 know, and I believe one of the attractions of this
7 country is the fact we have the free associations such
8 as hospitals and schools, where we haven't yet come to
9 the point where everything is placed in one form, one
10 mould, and we are completely reduced to the lowest common
11 denominator that must apply to every citizen, every child,
12 and every sick person. That is why we are asking the
13 Sisters to stay in this field.
14 Now, you ask if our position is being
15 endangered. The answer is yes, and I am going to give it
16 right back to Mother Dorais. She has more figures at her
17 fingertips to tell you why in some provinces the
18 association's position has actually be endangered.
19 MOTHER DORAIS: Mr. Chairman, in the
20 presentation of these recommendations we have the provi-
21 sion that we continue our ownership and operation of
22 hospitals in the true spirit of partnership. As you know,
23 this $350 million or so of capital value of hospitals
24 we have placed at the disposition of our Canadian people
25 for the implementation of hospital insurance throughout
26 Canada. However, in doing so we must be assured of two
27 major aspects of our operation: The capital costs and
28 the current costs. Regarding the current costs, if we
29 are to live under a true spirit of partnership with the
30 government at all levels, we now feel that decisions

and responsibilities for these decisions should be shared by all groups concerned. That is why in the brief, in the body of our brief we said we oppose certain formula of payments whereby the government would give certain block amounts and say, you distribute it the way you see fit. That may not be enough to go all around. It could be the social worker would say too much is going to the specialist; the specialist might say too much is going to the Sisters or the nurses. We would like the government to participate in the responsibility of the distribution of the funds that the government now furnishes for hospitals.

On the other hand, we would also like the hospitals, and we encourage them to do so, in preparing their budgets, to feel they are in partnership from the point of view of good standards of care and the possibility that the economics of our country could make possible such a budget be prepared. We don't feel that anyone at any level should have the discretionary power to cut the budget just because there isn't enough money to go around. If there is not enough money to go around then the public should know and should know why, not because hospitals are using too much, and if they are using too much, then the public should know.

We are now asking that these hospitals throughout Canada operate in the true spirit of partnership with all the levels of government. That is, of course, if all recognize that the institutions of the voluntary hospitals of which the Catholic Hospital is the most numerous be accepted is our Canadian society, and we

presume that it is.

Regarding the capital costs, when hospital insurance came into being in most plans, provincial plans, there has been no provision made to pay capital indebtedness as it stood at the time that these plans were implemented. As you know we speak of unmanageable debts in hospitals, and I think only on those debts do the government in some areas become interested. We feel that the public should know what these debts were, and should know what the public is receiving because those debts were incurred, and should also take the responsibility of developing a formula whereby these hospitals will be today on a sound financial basis, able to pay these debts. At this time, many hospitals, too many, throughout our country don't know how they will meet the commitments which they have loyally undertaken before the hospital insurance came into play. Have I answered your question, Mr. Chairman?

THE CHAIRMAN: Thank you, Mother Dorais. I think this recommendation, number one, it is in the preamble, perhaps, in the statement following that, you refer to the availability of chaplaincy services and the provision for a chapel in the religious hospitals. I think it was in Alberta we received a brief from the Chaplaincy Service of Calgary. Are you familiar with that service?

MOTHER DORAIS: Yes, I am.

THE CHAIRMAN: Does it exist elsewhere or in many places in Canada, that type of service as part of hospital administration?

MOTHER DORAIS: We have in some areas, Mr. Chairman, hospitals that have, right here in our City of Montreal, two chapels, one a Catholic chapel and one for a denomination who may wish to use the chapel. We have that in Montreal that I know of. So far I don't know of any Catholic hospitals where there has been a non-deominational chapel.

THE CHAIRMAN: It is perhaps inherent in what you say here on page 2, at least, as I read it, that are there places in Canada where the capital cost of the chapel is not recognized in the building of a Catholic hospital?

MOTHER DORAIS: Yes, Mr. Chairman, in Alberta and in Ontario.

FATHER DANIS: In Alberta, Mr. Chairman, there is no provision made for the building of a chapel, and there is difficulty in some hospitals in securing retribution for the chaplain's services, and in Ontario, I am under the impression though that we are not having any problem there, and in the majority of the provinces it is an accepted policy to have a chapel and to look after the administration of the chaplain.

THE CHAIRMAN: So it is really only in the one province that there is a problem?

FATHER DANIS: Yes.

SISTER MARY PATRICIA: To my knowledge there is no provision by the government for the construction of chapels in Ontario.

THE CHAIRMAN: Perhaps for the benefit of some of my fellow Commissioners, just what stress do

[illegible]

Mr. Chairman, [illegible] of Montreal. The [illegible] a convention [illegible] that in Montreal [illegible] any Catholic [illegible]

[illegible]

In what way [illegible] that are there places in [illegible] of the church is not [illegible] Catholic hospital?

Modern Funeral [illegible] Alberta and in Ontario.

[illegible]

There is no provision made for the [illegible] of a chaplain and there is difficulty in some [illegible] in obtaining such location for the chaplain's service, and in [illegible] I am under the impression [illegible] any problem there, and in the [illegible] it is an accepted [illegible] after [illegible] the chaplain.

Jew Cemetery. [illegible] in the one province [illegible]

[illegible]

Jewish and Catholic. There is no [illegible] there is no provision by the municipality for the consecration of burying a Jew.

Mr. Chairman. [illegible] of an [illegible] [illegible]

you place upon the need for a chapel in a Catholic hospital, and the necessity for it? Is this a point --- you put it in at the top of your brief ---- is it something of considerable importance in the Catholic hospital concept?

MOTHER DORAIS: It is of vital importance I would say, Mr. Chairman, and I would like to point out the chapel in a Catholic hospital is not only for the use of the Sisters and the personnel, but the spiritual need of the patient is part of the therapy he needs when admitted to a hospital, and we feel that a chapel not only for Catholics but for any denomination, should be made available for the use of the patients when needed, and it is vital and essential.

COMMISSIONER McCUTCHEON: I am not here to defend the Government of the Province of Ontario, but I have had something to do with raising money for hospitals in Ontario, and my understanding is that the money comes from roughly three sources, statutory grants on bed space and laboratory space generally. That is from the provincial government. Then from municipal governments, Catholic hospitals receive about a million and a quarter dollars. Then from the public. When you say there is no provision for government assistance for capital funds, I don't think those provincial grants have ever said you cannot spend the money on a chapel, and the government gives an over-all grant, plus a statutory grant. Is that right?

SISTER MARY PATRICIA: The grants are given on a per bed basis, and in some areas to my know-

lege, and this question came up in our own area, that the grant cannot help the construction of a chapel, but if you get a municipal grant you can use this.

COMMISSIONER McCUTCHEON: Or a flat grant from the government?

SISTER MARY PATRICIA: Are you referring now to the $75.00 per bed grant?

COMMISSIONER McCUTCHEON: No, I am referring to the grant of some hundreds of thousands made to St. Michael's Hospital by the provincial government, with no strings attached at all. That has happened in other communities. It may not have done in your community.

MOTHER DORAIS: I think the case applies in the Province of Alberta, where the in toto cost is supplied by the government, and the chapel is not recognized in the cost of the hospital when the ceiling is set by the government.

COMMISSIONER McCUTCHEON: The last hospitals that I know of in Ontario that were built entirely by the provincial government had a chapel built in.

DR. BOURGEOIS: You are surprised to see a layman participating in the Board of the Catholic Hospitals Association in Canada. I consider it a great honour, and I should like to stress the need that we have to have a chapel in a Catholic hospital. You would be surprised at the number of people who wish to go to the chapel. You would be surprised at the number of relatives, or parents, whose son or wife is in the

[illegible] the [illegible]

the event cannot help we [illegible] of a [illegible], but if you get a municipal grant you can use this.

DIRECTOR-GENERAL MONTGOMERY: [illegible] from the government?

GENERAL MARY BARTHOLOMEW: Are you [illegible] now to the [illegible] per year?

[illegible]

referring to the grant of some thousands of dollars [illegible] to St. Michael's hospital by the municipal government with no conditions attached at all. That has been [illegible] [illegible]. It may not have done so [illegible]

MOTHER DORAIS: I think the case applies in the Province of Alberta, where the [illegible] supplied by the government, and the capital is not [illegible] in the case of the hospital where the building is met by the government.

[illegible]

[illegible] I know of a [illegible] which [illegible] by the provincial government has [illegible] [illegible].

Mr. [illegible]: I have a suggestion to [illegible] paragraph 10 on the [illegible] Hospital Association [illegible] in [illegible]. I [illegible] of a [illegible] honour, and I [illegible] [illegible] have to have a grant in a [illegible] [illegible]. [illegible] be [illegible] at the [illegible] [illegible] to go to the [illegible]. You [illegible] [illegible] of the [illegible] of patients, or [illegible] [illegible]

operating ward and you would be surprised at the number of fathers who are waiting for their wife to deliver a child, and while they wait they want to go to the chapel. You would be surprised also to know that a hospital which has 28,000 emergency cases a year, the importance that a chapel acquires under such conditions. In certain cases many patients require to visit the chapel before undergoing operations.

I would say as a layman that I am convinced that the Catholic hospital absolutely requires a chapel, at least one.

In other hospitals we have two, so I do believe that in our own city, and in this province, we are convinced of the absolute need for a Catholic chapel in a Catholic hospital.

We are also convinced of the importance of a chaplain's services, because we are often obliged to require the services of a chaplain, of at least one.

We have established a system of visiting chaplains to serve all the patients. We also consider that a chapel in our institution is a service rendered to a patient.

THE CHAIRMAN: Thank you very much. Dr. Baltzan?

COMMISSIONER BALTZAN: Would you look at page 1, the lower last part of your paragraph in connection with the philosophy endows them, that is the Catholic hospitals, with special characteristics, which we feel, justify their continued existence.

By that statement, Mother Dorais, it seems

operating wards can not be supported as the number of laborers who are working for them is unable to deliver a child, and where they have their work to go to the charity. You would be surprised also to know that a certain [illegible] has 25,000 emergency cases a year, one hundred and a chapel requires a few such institutions. In country cases many patients require to go to the hospital before undergoing operations.

I would say as a lawyer that in [illegible] that the Catholic hospital successfully competes [illegible] at least one.

In other hospitals we have invited [illegible] believe that in our own city, and in the province, we are convinced of the absolute need for a Catholic channel in a Catholic hospital.

We are also convinced of the importance of a charitable service, because we are often obliged to require the services of a surgeon, or of [illegible] to have consultation a question of satisfying charitable to serve a [illegible] patient. [illegible] that a chapel in our institution is a service rendered to a patient.

THE CHAIRMAN: Thank you very much.

Dr. [illegible]?

CHAIRMAN'S RULING: Would you turn at page 1. The lower half of your [illegible] connection with the [illegible] [illegible], that is the Catholic hospital, with special [illegible], as we feel, justify their continued existence.

In that statement, however, it seems

to me that you and your associates feel there is a threat to the maintenance and continuity of the philosophy. Do you feel that with the new trend there is a threat to the maintenance and practice of them?

BISHOP CARTER: Yes, we do feel there is, not by the government, but just through force of circumstances. Before the National Insurance Act the public did support appeals for our hospitals. That is really how we kept going. Now, you know the mind of the public. Once the government has passed an insurance act, immediately people say: "Well, the government is paying the expenses. Why should we give anything to a hospital campaign?" And this large source of sustenance for our hospitals has been practically removed.

Now, we are also in the position where municipal hospitals are being looked after by municipal grants over and above what they receive from the Federal and Provincial governments, but a Catholic hospital in the same city, giving the same services to the entire population, if they want a grant from the municipal, the councillors and the aldermen, they are told: "You are a private hospital." This has happened in many instances, so we are going to be the victims of a squeeze play.

Our source of extra revenue has been fairly well removed, because the public say: "You are now in a government field and do not need assistance any more." You have the situation in a small city where the Catholic hospital, side by side, giving the same services, receives no recognition whatsoever. You can see immediately

to me that you and your associates feel there is a threat to the maintenance and continuity of the enterprise. Do you feel that with the recent trend there is a threat to the maintenance and practice of these

[illegible] is, not by the government, but just through lack of awareness. Before the national insurance act the public did support hospitals for our benefit. We is really how we [illegible] going. Now, you know the mind of the public. Once the government has passed an insurance act, immediately people say: "Well, the government is paying the expenses. Why should we give anything to a hospital campaign?" And this large source of awareness for our hospitals has been practically removed.

Now, we are also in the position where municipal hospitals are being taken either by non-profit groups over and above what they receive from the federal and provincial governments, but a catholic hospital in the same city, serving the same service to the entire population, is very much a great item to be municipalized. The conditions are two extremes, they are saying "You are a private hospital." This has happened in many instances, so we are going to be the victims of a squeeze play.

The problem in Cuba previous has been [illegible] well received, because the public says, "Look, you are now in a government [illegible] and so not need subscribe any more." You have the situation in a [illegible] city where the hospital [illegible], with by which, [illegible] the same [illegible], re

[illegible] of [illegible] in the [illegible], and so see [illegible]

that the existence of the Catholic hospital is called into question, because a community cannot pour money in if they cannot be sure of amortizing this debt and meeting the interest.

If a budget is based purely on an operating cost which does not take into consideration operation and interest, unless this is supplemented from another source, the community is in difficulty, and if it cannot go to the public or the municipalities where does this money come from? That is why I think we are at a very dangerous point with our Catholic Hospitals.

COMMISSIONER BALTZAN: Would you say the same argument applies to recommendation one, where you say that certain safeguards?

BISHOP CARTER: Yes, I think that that sums it up very well. It is the same basic difficulty which exists, isn't it?

COMMISSIONER BALTZAN: And it is not a question of any government. It is a question of certain tendencies in the way things are going today?

BISHOP CARTER: That is right.

COMMISSIONER BALTZAN: The last thing, and I happen to be harping on the same thing, on page four, and the Chairman has already referred to what you call the Bill of Rights under the present financial scheme, if things continue as they are, then you are threatened seriously with, well, a threat to your solvency, I am not going to say insolvency, a threat to the continuation of your operations, and that has become more so since the government has ceased participating

in contributions towards your establishments?

MOTHER DORAIS: That is right, Dr. Baltzan, and if we for a moment review the situation before the advent of hospital insurance and as it now stands. Before the per diem cost, the charge made to the patients, there was a sufficient amount, generally based on the sufficient norms of financial depreciation, and instead, on capital debts after retirement of debts, and the payment of interest thereon.

The moment that these hospitals went into the hospital insurance scheme and no provision whatever was made in Bill 320 for capital costs, and their current budgets of the hospitals, so on a cost basis then there were no provisions for payment or debts as they existed.

In some areas we have differentials which meet the difference for being paid by patients who occupied private and semi-private rooms. In some cases that may be sufficient, in many cases it is not. In most provinces today those differentials are the only source of revenue left to a hospital to meet any past capital commitments, or to meet any development which would be charged ordinarily to capital costs.

It is my presumption, Mr. Chairman, that the hospitals are now left with what we may term an empty title. We do not mind that, provided that the empty title does not leave us only with the responsibility of meeting deficits, such deficits upon which we have no control, because they would be the result of insufficient budgetary provision. That is why.

COMMISSIONER BALTZAN: Lastly, Mother Dorais, do you feel restricted also in relation to, say, operating costs in the hospital, or have you had that experience yet?

MOTHER DORAIS: I think we can pay a tribute to at least those plans that have been in existence for a few years, that they have contributed to the standard of patient care. However, as matters now stand, with all of our Canadians under a plan of hospital insurance, and that is why we call for extensive consultation between all parties who now form this partnership we spoke about earlier, in order that we may then together work out the proper norms to ensure the proper standard of patient care.

It goes for nursing, so much of it would have to be still in the area of research, to find out how much it really costs to take care of a patient. What we oppose is the one-party decision of cutting budgets, without making sure that at the same time they are not of necessity curtailing the adequate care of patients.

It is the partnership work which we are willing to go into wholeheartedly but we would ask governments to also do their share.

COMMISSIONER BALTZAN: Would I conclude then by thinking correctly that it is not a question of uniformity? It is a question of asking for a greater flexibility?

MOTHER DORAIS: Right.

COMMISSIONER VAN WART: Mother Dorais, since the inauguration of the hospital insurance plan

Dorsia, do you [illegible] in position [illegible]
opening [illegible] in the [illegible] or have you had that

[illegible]

MOTTA [illegible]: [illegible]
[illegible] least [illegible]
[illegible] for a few [illegible]
[illegible] of patient care. [illegible], as [illegible]
with all of our [illegible] under a [illegible]
insurance, and that is why we call for [illegible]
[illegible] between all [illegible]
we spend about [illegible]
[illegible]
[illegible] of [illegible] care.

It [illegible]
have to be [illegible] or [illegible]
how [illegible] to [illegible]
we [illegible] the [illegible]
[illegible]
of necessarily [illegible]

It is [illegible]
[illegible] we are
[illegible] to [illegible]

[illegible]
[illegible] a [illegible]
[illegible]

[illegible]

[illegible]
[illegible] the [illegible] of the [illegible]

have the Catholic hospitals proceeded with a capital expenditure programme at all?

MOTHER DORAIS: In some cases yes, but I would think that it is fair to say that it has been limited and you will realize the reason. It is impossible to budget the reimbursement of any capital debt at this stage, but of necessity now unless a clear-cut formula for payment of capital costs is set forth by the governments in every province, in order that we may budget, things must remain as it stands still.

COMMISSIONER VAN WART: Has it been limited more in the acute general hospital programme, or in chronic hospital programmes?

MOTHER DORAIS: I would say, Mr. Van Wart, that perhaps it is more evident in the acute, although we know the great need there is for the chronic programme.

COMMISSIONER VAN WART: In speaking of the need of the chronic care programme, do you feel that chronic care hospitals should be constructed in conjunction with an acute general hospital, or as a separate institution?

MOTHER DORAIS: Depending upon the type of medical and nursing care required for these patients, the answer to the question if some chronic care providing rehabilitation can be expected, it should be operated in conjunction with the general hospitals. It would help in the utilization of professional services.

COMMISSIONER VAN WART: Do you feel that from a financial point of view it would be more

economic to operate a section in conjunction with a general hospital than it would be to construct a new hospital for this type of people you are speaking about?

MOTHER DORAIS: Provided we know today that there are people in the acute hospitals that should not be using the expensive bed of an acute hospital, the answer to the question may be stated in terms of the need of the patient. If the patient needs medical attention and will get it more quickly by being in an institution operating in conjunction with the general hospital, perhaps on the same grounds or connected to it, in that case, yes, it would be in those cases whose rehabilitation is certainly expected within a relatively short period of time.

COMMISSIONER VAN WART: Do you feel under the present hospital insurance regulations that you couldn't take up such a programme financially at the present time?

MOTHER DORAIS: I think that the governments throughout our country have been very much open to the discussion of this problem, because it is a great need if we want to use those hospital beds that have been used for chronic cases and could be better used economically from the point of view of health than chronic cases.

COMMISSIONER VAN WART: But you feel you couldn't proceed financially under the present capital set-up in such a programme?

MOTHER DORAIS: I would not be competent to answer for all provinces.

FATHER DUROCHER: Mr. Chairman, I was wishing to point out that in Manitoba we haven't had any trouble with regards new buildings and so forth so far, and I think our plan is better adapted to the hospitalization scheme, and that the government has been quite generous in picking up interest charges, and things of that nature, and in allocating a certain percentage of responsibility to the voluntary organizations. Ways and means have been figured out where local municipalities can participate, so our problem has been mostly that of finding the personnel for all the different things which the government wishes to confide to us, and it has been less financial in that sense.

I think we owe it to our people in Manitoba to make this little explanation here today.

COMMISSIONER McCUTCHEON: Are there any other exceptions?

FATHER DUROCHER: Well, Mr. McCutcheon, I was thinking when Sister Dorais spoke, I was trying to think of a province where there has not been one widely publicized case of trying to finance, and I think Manitoba is the only province whose shield has been clear.

BISHOP CARTER: I have to go along with Commissioner McCutcheon and agree that the Province of Ontario has been an exception. These have been special considerations given out of the goodness of the heart of the Prime Minister or the Minister of Health, but it is not a programme, and I think it is dangerous if you have a programme generally depend upon the goodwill of persons whose thinking may change, looking at an over-all

[illegible]

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trouble with regards to conflicts and so forth as far,
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of responsibility to the voluntary organizations. We
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finding the personnel for all the different things which
the government wishes to provide to us, and it has been
less financial in that sense.

I think we owe it to our people in
Manitoba to make this little explanation now.

COMMISSIONER MODERNACHAN: [illegible] there any
other exceptions?

PROVINCE SPEAKER: Well, Mr. Modernachan
I was thinking when Doctor Dorsia [illegible], I was trying to
think of a province where there has not been one wholly
publicized case of [illegible] to Kansas, and I think
Manitoba is the only province where [illegible] has been [illegible]

[illegible]: I have to go along with
Commissioner Modernachan and agree that the province of
Ontario has been an exception. There have been special
considerations given one of the gentlemen of the depth of
the Prime Minister or two ministers of Health, but it is
not a programme. And I think it is dangerous if you have
a programme generally depend upon the goodwill of persons
whose [illegible] may change. Nothing at all [illegible]

programme.

The system itself, with the exception apparently of Manitoba, does give us certain cause for concern, and I think too we might mention here, as the Sisters would be too modest to say so. When they run those hospitals, they are kind of geniuses at economy, and by working long hours and by enlisting many of their nurses to work at lower salaries than the going salary, they are able to run small hospitals at a lower profit, which enabled them to pay back their interest and some of their capital, but today this is no longer true, because the nurses demand the going salary, and I think they are quite right in doing so.

THE CHAIRMAN: I think Mr. McCutcheon, a word may even be said for Saskatchewan. I think Mother Dorais will corroborate this very freely. Perhaps the first large rebuilding programme in a religious hospital is now in process in Saskatchewan with very substantial governmental assistance, certainly on a very generous scale.

MOTHER DORAIS: Yes.

COMMISSIONER McCUTCHEON: Sometimes you do better without a programme you know.

MOTHER DORAIS: That is very true, Mr. McCutcheon, that is probably why the shortcomings of the Alberta programme came out, but I will say, Mr. Chairman, that in Saskatchewan, as well as in Manitoba, and those are, of course, spot checks, because our experience is still short-lived with it. In the particular institution you are referring to, Mr. Chairman,

it would seem that the owners will contribute some twenty per cent of the entire capital costs. Now, in Manitoba you have had as an appendix to our presentation the various capital formulae throughout Canada, and in Manitoba eighty per cent of the capital cost is shared through the formula of depreciation on the buildings. It will be paid with the interest on that eightyper cent capital debt. So that twenty per cent remains with the owners. It would seem at this stage, subject to further studies and further research, that owners may not at any time go beyond twenty per cent, and that would be providing there is this ratio of private preferred accommodation in public wards to make this ratio available for capital costs.

COMMISSIONER GIRARD: Mr. Chairman, I have no questions regarding nursing education, not that I didn't try to find some. I did, really, but these recommendations in these chapters are so clear and so concise, so forward looking and so progressive, that they are written after my own heart. I endorse them entirely and I hope the rest of the Commission will also.

THE CHAIRMAN: You are most persuasive, you know.

COMMISSIONER GIRARD: I must add this is not surprising, if you will realize, gentlemen, you have before you here this morning some of the most outstanding leaders in nursing education in Canada, some of the most prominent members of the Canadian Nurses' Association. I don't have to name them because they are all here, those that are sitting in front, and there are

some in the back, so that is why these recommendations on nursing education are so good. They say exactly what I would have said or I couldn't have said it better, or I couldn't have said it as well.

THE CHAIRMAN: Dr. Firestone.

COMMISSIONER FIRESTONE: Mother Dorais: In your recommendation three on page four you recommend a revision of the Hospital Insurance and Diagnostic Services Act to secure recognition of the depreciation of buildings and physical plant and on interest on capital short term loans as shareable costs of operations. Has the Catholic Hospital Association of Canada made any representations to the Federal Government in this respect?

MOTHER DORAIS: Yes, indeed, Mr. Firestone, on many occasions.

COMMISSIONER FIRESTONE: What reply have you received?

MOTHER DORAIS: It would be most intersting to have time to read the various reports we have received.

COMMISSIONER FIRESTONE: Would a summary be possible on this occasion, just the gist of it?

MOTHER DORAIS: I will try to do so, Dr. Firestone.

First of all, at no time has anyone taken exception to the principle of interest and depreciation being recognized as true costs of operation.

THE CHAIRMAN: That is on a proper

actuarial basis?

MOTHER DORAIS: It is recognized by Income Tax laws, I understand. It has always been taken into account in all financial concerns. There is a problem here though, that we do realize, and we wish to co-operate in trying to meet it. As far as interest, there is no problem if there is no debt, there will be no interest. As far as depreciation, certain large institutions here in our own metropolitan area, for instance, at the present time are without debt, because they have raised large contributions in public fund raising compaigns before our hospital insurance scheme. If they were to be paid depreciation they may have funds available that wouldn't be immediately required. We recognize that problem regarding depreciation for hospitals. As well, at the same time, we recognize that there must be over-all planning of future construction of beds and there should be where they are needed. On the other hand we are looking for a formula which would resolve, so to speak, the philosophy of financing of governments whereby entire capital costs are paid in the year they are incurred through budgets, and the philosophy of profit making organizations where necessary depreciation must be available to provide working capital and to provide plant capital. We recognize that these hospitals are providing a service to the public and we wish to co-operate, but as there is not a formula that would recognize these two principles of financing, and that would be applicable to the non-profit organization operating today in those institutions and having as

we pointed out earlier, an empty title. What is that formula? What can it be?

We have said earlier in our presentation it has been discussed, one programme in Saskatchewan and another in Manitoba. If this formula could have been found when Bill 320 became law in 1957, then we would have had this through the provinces, a programme which made possible budgeting for capital costs, not irrespective of regulations and of new planning. Within that we are willing, and I must repeat, and I emphasize it, we are willing to operate these institutions under the true spirit of partnership with our governments.

Accountants before they became involved in government, recognized this principle and said so, but perhaps when it comes to another level, it creates difficulty in its application.

There is another formula and I am sure the Canadian people will find it which will make possible the voluntary institutions and will keep this wonderful capital of people willing to serve our nation, and at the same not not make it a completely State institution. That is what we are willing to work with you to find. At this stage the only formula that is studied, it is of financial grants, interest and depreciation is part of cost of operation. What we want is a formula whereby within the structure of the cost of operation formula, the capital cost of the institution will be taken care of and our hospitals will be solvent, to use the expression of Dr. Baltzan.

BISHOP CARTER: It I might, very briefly,

[illegible] particular, an county [illegible]. What is that [illegible]

We have had another in our government [illegible] which has been discussed, one proposed in Saskatchewan [illegible] another in Manitoba. I think Nevada could have been found when Bill 320 became law in 1957, then we would have had this through the province, a programme which made possible budgeting for capital [illegible], not inappropriative of regulations and of new planning. Within that we are willing, and I must repeat, and I emphasize it, we are willing to operate these institutions under the true spirit of partnership with our governments.

In government, recognized this complexity and said so, but perhaps when it comes to another level, it creates difficulty in the application.

There is another [illegible] and I am sure the voluntary institutions [illegible] very high [illegible] capital of people willing to serve our nation, and at the same not put make it a complete state institution. That is what we are willing to work with you on that. At this time the only Nevada that is studied, is in of financial [illegible], interest and capitalization is not of cost of operation. What we want is a [illegible] [illegible] the structure of the cost of operation [illegible] the important cost of the institution will be [illegible] of and our hospitals will be salvaged, to use the expression of Dr. [illegible].

[illegible]: [illegible], very [illegible]

make a direct answer to Dr. Firestone's question: I was with Mother Dorais on a joint delegation from the Canadian Hospital Association and the Canadian Catholic Hospital Association that met with the Prime Minister and Mr. Monteith shortly after the government took office. I said to Mr. Monteith, you are an accountant, sir, do you admit that a per diem rate is only realistic if you take construction and interest in any business, so, he said, yes, that was true. I said, why should hospitals be different. They have to function in the business-like way of other institutions. He admitted the validity of the argument and the whole thing ended by the Prime Minister and the Minister of Health and Welfare stating they were in complete sympathy with our request. They would study it, but the man we had to convince was the Minister of Finance.

MOTHER DORAIS: Father Durocher might tell us some pilgrimages he and I made when Bill 320 was being considered in the House.

FATHER DUROCHER: I think it would be proper to point out these remarks could be made without any political implication. We are involved with all political parties. Some brought it in, some continued. Some tried to find solutions and so forth. We can speak very freely, as you very well know.

MOTHER DORAIS: I would like to add on this particular question, because I have felt in Ottawa where we have made several pilgrimages that there is the wrong interpretation of the fact that if depreciation and interest were paid on the cost of the operating, then

make a direct answer to Dr. [illegible] a [illegible]

I was with Mubin Lynch upon [illegible] [illegible] the

[illegible]

and the [illegible] [illegible] other the [illegible]

I am [illegible] Mr. Speaker, you are an accountant, [illegible] do

you point out a [illegible] difference [illegible]

these [illegible] [illegible] in any [illegible], so, he

said, yes, that was true. I [illegible], we should [illegible]

be different. [illegible] have to [illegible] in the [illegible]

way of other [illegible]. [illegible] adopted the [illegible]

the [illegible] and the whole [illegible] [illegible] by the Prime

Minister and the Minister of [illegible]. [illegible]

they were in [illegible] with [illegible]. [illegible]

would [illegible] it, but [illegible] to [illegible] the Minister of Finance

[illegible] Mr. Speaker: Perhaps the [illegible] [illegible]

tell us some [illegible] be [illegible] I made when [illegible]

before [illegible] in the House.

[illegible] I [illegible] [illegible]

proper to point out these [illegible] could be made [illegible]

any [illegible] [illegible]. [illegible] involved with all

[illegible] [illegible] [illegible] [illegible], some [illegible],

some [illegible] [illegible] [illegible] [illegible]. [illegible] [illegible]

very [illegible], [illegible] very [illegible].

[illegible] I would like to [illegible] [illegible]

this [illegible] [illegible], [illegible] I have [illegible] [illegible]

[illegible] have [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] of the [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible]

the government would own the hospital. I think the members of the Commission realize this isn't so. Depreciation and interest in any profit organization doesn't give the right to those who are interested in the organization to own the place if they made a certain amount of purchases. We have played around, but the principle still remains that it is, interest and depreciation on the cost of operation.

COMMISSIONER FIRESTONE: Mother Dorais, under what circumstances would interest obligations for short term loans arise?

MOTHER DORAIS: Ever since the implementation of hospital insurance throughout Canada it has been very evident that working capital has become seriously depleted, so seriously depleted that here in our own province at the present time we have huge short term loans at the bank to meet current salaries, current bills, and there will have to be short term loans if there is not sufficient working capital available.

COMMISSIONER FIRESTONE: Is this due to the fact that the payments which the hospital receives are at intervals which make it difficult to meet the current commitments, or at what intervals are hospitals in receipt of payments from provincial governments under the plan?

MOTHER DORAIS: I would rather think, Dr. Firestone, it is caused by the fact these payments are not of sufficient amount, because in some provinces these payments come in twice monthly. Generally the salaries will be payable every two weeks and accounts

the government would own the hospital. I think the members of the Committee realize that i.e. incorporation and [illegible] credit cooperatives doesn't give the right to those who are interested in the organization to own the place if they make a certain amount of purchases. We have played around, but the principle still remains that it is, interest and depreciation on the cost of operation.

CONTRIBUTORY PROVINCES: Neither Canada under that circumstances would recommend contributions for short term loans anyway.

Implementation of Capital Improvements Revolving Fund

It has been very evident that our [illegible] has become seriously depleted. We continually deplore that there is our own provision for the present time be have long-term loans at the same to meet current expenditure. Currently it is, and I have all have to be right been cases in there is not sufficient revolving capital available.

CHAIRMAN PRESENT: In this one to the floor that the Committee with the hospital revolving are an [illegible] which were [illegible] to meet the current expenditure, or at what interests are hospitals an [illegible] of [illegible] from provincial governments [illegible] the [illegible]

MEMBER CANADA: I would remember that, Mr. Chairman. It is [illegible] by the fact that [illegible] are not of such great amount, because it [illegible] these expenses [illegible] in their monthly. Generally the patients will be [illegible] every two weeks and [illegible]

payable every month. The time is sufficient. The amount very much insufficient.

COMMISSIONER FIRESTONE: Why are the amounts insufficient?

MOTHER DORAIS: Because the budgets so far haven't been approved as presented by the hospital administrators. This, I wouldn't want to be considered as a plea from our group that these budgets should always be approved as they are presented, but I think that before these budgets are curtailed there should be a very clear-cut round-table conference as to why they are cut. If it is a matter of national economics the public should know of the hospital needs. Governments need hospitals and the sooner we get together so that we have really constructive publicity about patient care, the better it will be, at least, for the hospitals.

COMMISSIONER FIRESTONE: Mother Dorais, these budgetary discussions take place between the hospitals and the provincial government?

MOTHER DORAIS: Right.

COMMISSIONER FIRESTONE: What could the Federal Government do to help in such discussions? You will appreciate, Mother Dorais, this is a Royal Commission advising the Federal Government in Ottawa. We would like to have some advice what we should say to the Federal Government to improve the existing system which means -- many of the difficulties seem to be based because provincial governments and hospitals are not able to agree on what are reasonable budgets and what are not reasonable budgets. What could the Federal Government do?

MOTHER DOGETS: [illegible] the budgets so far haven't been approved as presented by the hospital administrators. This, I wonder, need to be considered as a plus from our point that these budgets should always be approved as they are presented, but I think that before these budgets are submitted there should be a very clear-cut, common-sense conference as to why they are right. If it is a matter of emotional economics the public should know of the hospital needs. Governments need breathing and the sooner we get together so that we have nasty somebodyness publicity about patient care, the better it will be, at least, for the patients.

(MODERATOR KIRKPATRICK: Mayor Dogets, these budgetary discussions take place between the hospitals and the provincial governments.

Federal Government do in Ireg it seem discussions? You will supposedly, Mayor Dogets, that is a Royal Commission advising the Federal Government in Ottawa. We would like to have some advice what we should say to the Federal Government to improve the existing system which means -- some of the difficulties seem to be from the provincial governments. Hospitals are not able to serve on more the reasonable salaries and have not reasonable budgets. Just could the Federal Government do

MOTHER DORAIS: Dr. Firestone, if you will permit, when Bill 320 came into operation, there was there a financial formula whereby the Federal Government would pay twenty-five per cent of the per diem cost of the province and twenty-five per cent of the per diem cost of our cost of taking care of patients. With this formula some provinces are receiving much more than fifty per cent of their total cost. Others are receiving somewhat less than fifty per cent. These provinces receiving less than fifty per cent of the total patient care, these provinces where the standard of care and the conditions of employment were such that the cost was already quite high on a comparative basis.

The Federal Government now has at hand all this information. They know this percentage will go from seventy per cent to, perhaps, forty-six per cent in some of the provinces. There is, I think, in the Federal Government sufficient data available to, on the basis of research, find out why this cost varies from province to province. If it is because the work week is too long, because there isn't a sufficient number of nursing hours per patient day, all these things I suspect can be determined on the basis of the statistics available on the national level, and from there a proper diagnosis made as to what could be done to help.

They could possibly augment into those agreements that the Federal Government enter with the provinces, if it is the objective of the Federal Government to give equal standards of care to all citizens of Canada, regardless of the province or the latitude where

[illegible]

will remit [illegible] was there a financial formula whereby the federal government would pay [illegible] per cent of the pension [illegible] of the province and twenty-five per cent of the per diem cost of the cost of [illegible] or [illegible]. [illegible] they [illegible] per cent of their total cost. Others are receiving [illegible] [illegible] less than fifty per cent of the total maximum rate, these provinces raise the standard of care and the conditions of employment were such that the cost was already quite high on a comparative basis.

The Federal Government [illegible] all this information. They know this percentage will go from seventy per cent to, perhaps, forty-six per cent in some of the provinces. There is, I think, in the Federal Government sufficient data available to, on the basis of research, find out why this sort varies from province to province. Is it because the work week is too long, because there isn't a sufficient number of training hours per patient day, all these things I suspect can be determined on the basis of the statistics available on the national level, and then make a proper diagnosis as to what could be done to help.

They can't possibly enforce [illegible] these requirements [illegible] the Federal Government [illegible] with the provinces, if it is the objective of the Federal Government to give equal standards of care to all persons in [illegible] because of the [illegible] where

they live.

COMMISSIONER FIRESTONE: Has the Canadian Catholic Hospital Association of Canada a specific amendment to suggest in respect of the formula presently used that the Federal Government could incorporate into the Act?

MOTHER DORAIS: The Act as it now stands regarding current operation, covers everything without any -- is not related to any figures, so that is fine. It would be within the agreement of the Federal and Provincial Governments, such agreements, of course, I would say, Dr. Firestone, the hospitals are not aware of. In our province here, it is the only province in Canada where the hospitals have been called upon to sign a contract with the provincial government in order to make the hospital eligible to receive funds from our provincial government.

COMMISSIONER FIRESTONE: As I understand it, you feel that the formula as presently in use, which has the effect that some hospitals in some provinces receive higher portions of hospital cost are not equitable because others are getting less, therefore, the basis of those agreements ought to be altered to be more equitable.

The question is: How should they be altered? If you have no other suggestion please feel free to say so and we will think about it, and you may want to think about it too.

MOTHER DORAIS: I am not saying it is not equitable. Most likely it is equitable on the basis of

amendment to suggest it respecting of the formula recently used that the federal government would increasingly pay the Act?

[illegible] section, covers everything [illegible] -- is not relevant in any figures, so that is from it would be within the agreement of the federal and Provincial governments, such agreements, of course, I would say, Sir. Nevertheless, the hospitals are not [illegible] of. In our province here, it is the only province in Canada where the hospitals have been called upon to enter a contract with the provincial government in order to take the hospital [illegible] to receive funds from our provincial government.

MR. SPEAKER: [illegible] As I understand it, you feel that the formula as presently in use, which has the effect that some hospitals in some provinces receive higher contributions of hospital cost are not equitable because others are getting less, therefore, the basis of those agreements ought to be altered to be more equitable.

The question is: How should [illegible] alternate? If you have no other suggestion, please [illegible] time to say so and we will think about it, and you may have to think about it too.

MR. [illegible]: I am not saying it is inequitable. What I am [illegible] is the [illegible]

the patient standards of care in our country, but I would say if the objective of our government, Federal Government should be the standards of care should gradually come up to the same level throughout our nation, and when they reach that level then the cost will be the same everywhere.

COMMISSIONER FIRESTONE: Would you say, Mother Dorais, for example, that one provision could be, under no circumstances should the Federal Government's share be less than fifty per cent. You suggested it was going down below fifty per cent. I am looking for something specific that one could consider as a possibility to deal with the problem. There may be other possibilities.

MOTHER DORAIS: I was looking more from the point of view of norms that every province should meet rather than fiscal formula.

COMMISSIONER FIRESTONE: Thank you for your comments, Mother Dorais. We will have to consider the fiscal implications somewhat further.

May I just have one clarification of your recommendations. When you speak of interest on capital and short term loans as shareable costs of operation, would this cover interest charges relating to capital costs and short term loans incurred since the Hospitalization Insurance and Diagnostic Act has come into operation, or would it also cover old debts?

MOTHER DORAIS: Yes, there must be provision made for interest on old debts, but on short term loans, for instance, during the period of construction at the present time the government gives their

grants on this construction as it is advanced, as the work is carried on the government will pay their grant on the basis of twenty-five per cent completion of the work. Until we reach the twenty-five per cent, the holders' certificates must be met, and if there is no available capital we must borrow with very heavy interest. On these conditions governments don't recognize interest as they don't recognize interest on bank overdrafts because of insufficiency of working capital.

COMMISSIONER FIRESTONE: Therefore, your recommendation covers interest on all capital loans outstanding?

MOTHER DORAIS: Right.

COMMISSIONER FIRESTONE: And on short term loans outstanding?

MOTHER DORASI: Right.

COMMISSIONER FIRESTONE: Thank you very much, Mother Dorais.

COMMISSIONER McCUTCHEON: Mother Dorais, on the question of depreciation, leaving aside the old debt for the moment, on the question of depreciation would it be your view if depreciation were to be allowed on that portion of fixed plant installed after the coming into effect of Bill 320 or the implementation of legislation in any particular province, and this only would exist when the funds came from others than government or from voluntary services?

MOTHER DORAIS: Depreciation -- what the government has paid through grants, I don't feel it would be right to require depreciation on.

Rights in this co-operation. If it is forthcoming, the work is carried on the government will pay their share on the basis of twenty-five per cent of the work. Until we reach the twenty-five per cent, the federal certificates must be met, and if there is no available capital we must borrow with very heavy interest. On these conditions governments don't recognize interest as they don't recognize interest on bank overdrafts because of insufficiency of revenue earning.

COL. THELANDER, PRESIDENT: Therefore, your recommendation covers interest on all capital loans outstanding?

CHARLES DUNN, PRESIDENT: And on short term loans outstanding.

MR. [illegible]: Member Downie.

DOUGLAS DOWNIE, MEMBER: Member Downie, on the question of depreciation, leaving aside the old debt for the moment, on the question of depreciation would it be your view if co-operatives were to be allowed on that question of fixed plant financing after the coming into effect of Bill 160 or the implementation or legislation in any permissive provision, and this only would exist when the funds were there from government or from veterans' services?

MR. [illegible]: Depreciation - what the [illegible] has put into the pamphlet, I don't know. It would be right to consider depreciation on.

COMMISSIONER McCUTCHEON: Right.

MOTHER DORAIS: Depreciation on all investments made through funds made available on a voluntary basis.

COMMISSIONER McCUTCHEON: Funds donated by the public?

MOTHER DORAIS: Donated by public campaign, donated by nurses, all funds weren't government funds.

COMMISSIONER McCUTCHEON: I would think it would have met your requirements if you limited it to funds given by, say, the religious community or the nurses, but you wouldn't expect to collect depreciation on money that I might contribute to you?

MOTHER DORAIS: The question is a little difficult to answer, Mr. McCutcheon, because as it was earlier indicated, these fund raising campaigns are becoming more and more difficult to handle.

COMMISSIONER McCUTCHEON: If they are, the formula would take them.

MOTHER DORAIS: If they are, and if there are no more funds we can obtain from that source, we will have to find another formula. If the nurses -- the voluntary institutions have no taxing power of any kind. We must find a formula on that basis. That is why what we want is capital costs to be taken care of through the current operation, through the financial structure of the current operation of the hospital. In other words, based, of course, on the needs and approval of government of such needs.

COMMISSIONER McCUTCHEON: Thank you very

much.

COMMISSIONER GIRARD: Mr. Chairman, I do have another question that I forgot to ask a little earlier. It is merely to report a sin of omission, not on my part.

Why did this brief not refer to nursing services and why did it refer only to nursing education? I was looking forward to getting some good education on nursing service. I think the Catholic hospitals are very concerned with service, not only education.

MOTHER DORAIS: Sister Felicitas.

SISTER FELICITAS: Mr. Chairman, Miss Girard, nursing service is implied in this. Perhaps we didn't bring it out to the fullest extent as Miss Girard would have liked us to. However, I think you will notice that in the recommendations we have asked for financial support for salaries, first of all, in the administrative level, supervisor level, as well as teaching, for bursaries to give post-graduate education to those in the nursing service areas, and of course, we referred to the fact that in preparing nurses and in giving nursing education we are preparing them for nursing service, and we do feel if we can improve nursing education we will improve the nursing service. The better prepared our nurses are the better they may serve the people of Canada.

COMMISSIONER GIRARD: Thank you, Sister Felicitas. I realize all this. We do accept education is for service, but there are such interesting questions nowadays in nursing service, nurses and unions and so on and so forth. Maybe we could get that into a nice

discussion and I could be enlightened, but I understand that you really do think of nursing education as the basis for nursing service. Thank you very much.

THE CHAIRMAN: Does anyone in your delegation, Mother Dorais, have anything further to add?

I want to thank you very much, Mother Dorais, Bishop Carter, Father Durocher, Father Danis, Dr. Bourgeois and Sisters. This is a very enlightening brief and this Commission is fully aware of the importance of the subject treated here this morning and your representation will have our most earnest consideration.

BISHOP CARTER: Mr. Chairman, may I express the gratitude of the delegation to the members of the Commission for their sympathy and kind attention and their very construc tive questions. They have brought out points that are not entirely clear in the brief. We go away with the feeling there is mutual understanding in the hospital field, with the exchange of ideas and questions here. We are all very deeply grateful to you. Thank you.

----- Short recess.

THE CHAIRMAN: If we may now come to order, we will proceed.

We have the Canadian Medical Association, Province of Quebec Division, and the submission will be exhibit number 235, the English translation 235A.

[illegible] and I [illegible] a [illegible], but I [illegible] that you people do this of [illegible] education [illegible] the

THE CHAIRMAN: Does anyone in [illegible] consideration, Member Dunning, have anything further to [illegible]

I want to thank you very much, Mother Teresa, [illegible] Carter, Father Dunning, Father [illegible], Dr. [illegible] for listening. [illegible] in a very enlightening brief and they have an in depth sense of the importance of the work [illegible] and your representation will have our most serious consideration.

[illegible] express the gratitude of the delegation to the members of the Committee for their sympathy and kind attention and their very courteous [illegible]. They have [illegible] one [illegible] that are not only clear in the [illegible]. We [illegible] with the feeling there is indeed understanding in the Committee, with the exception of [illegible] and other [illegible]. We are all very deeply grateful to you. Thank you.

[illegible] Carter to come.

Mrs. [illegible]: [illegible] to go, now come to order, we will proceed.

[illegible] have the [illegible] Minister responsible, Province of Ontario Division, and he [illegible] will be [illegible] Chairman [illegible].

SUBMISSION

of the

QUEBEC DIVISION, CANADIAN MEDICAL ASSOCIATION

Appearances;

Dr. Thomas R. Hale

Dr. Normand-J. Belliveau

Dr. Victor C. Goldbloom

Dr. T. James Quintin

Dr. Rene-L. DuBerger

--- EXHIBIT NO. 235: Submission of the Quebec Division, Canadian Medical Association.

--- EXHIBIT NO. 235A: English translation of exhibit number 235.

DR. DuBERGER: Mr. Chairman, ladies and gentlemen, it is a great pleasure for me to appear before you to present on behalf of the delegation of the Division of Quebec of the Canadian Association this brief.

First of all, I should like to say a few words of welcome, and to say how happy I am to be at this Royal Commission here in Montreal, in the Province of Quebec. I don't want to pass in silence the appointment of the Dean of the Faculty of Nursing, and I should like to say that we are very happy that this appointment has been made. We think it is a very good appointment.

To my extreme left we have Dr. Tom Hale, whose smiling confidence is a replica of the fact that

Dr. Hormand-J. Jellivean

Dr. Victor C. Gotcelcom

Dr. T. James Quintin

Dr. Rene-L. DeBergue

--- EXHIBIT NO. 235: Speech-notes of the Quebec Minister, Canadian Medical

--- EXHIBIT NO. 235A: French translation of exhibit number 235.

and gentlemen, it is a great pleasure for me to appear before you to present on behalf of the delegation of the Division of Quebec of the Canadian Association these

First of all, I should like to say a few words of welcome, and to say how happy I am to be at this Royal Commission here in Montreal, in the province of Quebec. I don't want to pass in silence the appointment of the Dean of the Faculty of Medicine, and I should like to say that we are very happy that this appointment has been made. We think it is a very good appointment.

To my extreme left we have Dr. Jean Drolet, medical consultant to a region of the Fort Nord that

he is our Public Relations Chairman. Then, Dr. Normand Belliveau. He is a Canadian, and comes from Nova Scotia, and says that his ancestors came here with Eric the Red. Victor Goldbloom had the responsibility of preparing this brief, and is the President of our Economics Committee. Dr. Quintin is a Past-President of our Division, and is also the Past-Chairman of the Economics Committee.

Now, I would like to introduce for the brief itself Dr. Goldbloom, and I would like to add that Dr. Goldbloom will be glad to answer any questions either in French or in English.

DR. GOLDBLOOM: Mr. Chairman, madam, and members of the Commission, since there is simultaneous interpretation I will not have to say twice what I have to say, but in order to stress the bilingual nature of our Association, I would like to read the first part of the brief in French and the second part in English.

The demand for medical services exceeds the supply of personnel to provide them. The discrepancy is even greater in paramedical fields.

The working hours of the average-physician exceed by a wide margin those considered suitable for most occupations. A numerical increase is already necessary, and will become more so as the population expands; the only alternative will be a deterioration in quality and quantity of care.

Steps should be taken to expand the facilities for education and post-graduate training in this province. Future needs and future demands cannot be met without an appreciable acceleration of the production of

he is our Public Relations [illegible]. Then, Dr. [illegible] believed. He is a [illegible] from [illegible] and says that his [illegible] [illegible] with the [illegible] Victor [illegible] and the responsibility of [illegible] that [illegible], and is the President of our Economics Committee. Dr. [illegible] is a Past-President of our Association, and is also the Past-Chairman of the Research Committee.

Now, I would like to introduce the [illegible] Dr. [illegible], and I would like to ask Dr. Goldthorpe will be glad to answer any questions either in French or in English.

DR. GOLDTHORPE: Mr. Chairman, [illegible] and members of the Commission, since there is simultaneous interpretation I will not have to say twice what I have to say, but in order to address the [illegible] [illegible] of our Association, I would like to read the French part in the order in French and the second part in English.

The [illegible] in medical services exceeds the supply of personnel to provide them. The [illegible] is even greater in paramedical [illegible].

The average rates of the [illegible] physician exceed by a wide margin those considered [illegible] for most occupations. A [illegible] increase is already necessary, and will become [illegible] as the population expands: the only alternative with [illegible] is a deterioration in quality and quantity of [illegible].

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physicians.

The current rate of net annual increase would almost, but not quite, maintain present ratics through 1980; but the annual increase in practising physicians is too small a proportion of the total.

With these considerations in view, the Division offers the following recommendations:

(a) That the Federal and Provincial Governments undertake a sincere effort to reach a mutually satisfactory arrangement for the best application of Canadian financial resources to Canadian education, Canadian research, and Canadian health services.

(b) That, as a result of such an accord, all necessary aid be made available to the University of Sherbrooke to ensure the earliest possible opening of its Faculty of Medicine.

(c) That, since the three Faculties of Medicine already existing have virtually reached reasonable limits of size and efficiency, the possibility of expansion at Sherbrooke, and alternatively of the foundation of a fifth Faculty of Medicine in the province, be carefully studied.

(d) That the financial burden of medical education, already subsidized to the extent that student fees represent less than 20% of its cost, but still one of the most expensive fields of study in any university, be lightened in order to attract more students. That this be done partly by government contributions to universities to permit the lowering of fees, and partly by the expansion of bursaries and of loan programs.

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(b) That, as a result of such an agreement, all necessary aid be made available to the University of Sherbrooke to ensure the continued possible operation of the Faculty of Medicine.

(c) That, since the medical faculties of Medicine already existing have virtually reached economic limits of size and efficiency, the possibility of expansion at Sherbrooke, and alternatively of the foundation of a fifth Faculty of Medicine in the province, [illegible]

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(e) That the economic status of internes and residents be improved, in proportion to their extra years of non-remunerative education in comparison with most other professions.

(f) That paramedical education be supported in parallel and in proportion to medical education.

(g) That funds for research be doubled in the immediate future, and then increased by about 7% per year thereafter.

(h) That universities be encouraged to take a greater community responsibility in medical and paramedical education, e.g.:

(1) in fostering interest in these professions, and attracting students to them;

(2) in adapting patterns of education to community needs, and thereby influencing such factors as the proportional production of specialists and general physicians (and therefore the patterns of their utilization in the community);

(3) in participating more actively in post-graduate education, with considerably increased budgets for this function;

(4) in fostering bilingualism, and any other quality which would make the physician or paramedical worker more useful in the community and give him or her a fuller life.

(i) 8,000 hospital beds, mostly for

(e) That the economic status of teachers and possibly be improved, in proportion to some system of non-teaching education to compensate such other professions.

(f) That vocational education be adjusted in general and to provision to medical education.

(g) That in the preparation a course in the immediate future, and then increased in succeeding years thereafter.

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(4) in fostering bilingualism, and any other quality which would make the physician or surgical nurse more useful in the community and also [illegible]

(5) 5,000 [illegible] per, mostly for

chronic and convalescent care, are needed immediately; by 1980, an additional 21,000 beds of all kinds will be necessary. No estimate is made for facilities for mental health and mental illness, since these are at present under study by a provincial Commission.

The Quebec Division of the Canadian Medical Association was founded in 1922 as the Province of Quebec Medical Association, which name it still retains, and was incorporated into the national body in 1938. It is a voluntary association of more than 2,500 members throughout the province, 57% of the membership being French-speaking and 43% English-speaking.

The chief purposes and functions of the Division are:

(a) to provide professional and educational services to its members, by holding general and district meetings on topics of interest, and by offering speakers for medical presentations throughout the province;

(b) to maintain liaison, through the national organization, with 12,500 confreres across Canada;

(c) to express, through its representatives on the national Executive, national General Council, and numerous national committees, the point of view of the profession in this province; and thereby

(d) to sustain, at a national level, the cultural heritage and linguistic identity of French Canada.

In this province, as in all others, the general practitioner is the backbone of medical practice.

This Division, through its Committees on General Practices and Postgraduate Education, among others, and through its association with the Quebec Chapter of the College of General Practice of Canada, supports the on-going education of the general physician and the maintenance of his standards.

This Division looks with favour on the development of Departments of General Practice in general hospitals, and will continue to do its part in helping the general physician to attain and retain the necessary qualifications. We believe that contact with a hospital milieu plays a significant part in maintaining and elevating quality of care. The concept of a Department of General Practice is different from that of an open hospital, and is as applicable to a teaching hospital as to any other.

It is the feeling of the Division that in the future the ratio of general practitioners to specialists should rise; that in some specialities a greater proportion of the specialist's time should be used for consultation and teaching; and that encouragement and inducement should be offered the medical student to consider general practice a worthwhile and desirable career.

BASIC CONSIDERATIONS IN HEALTH CARE PLANNING

In the minds of political parties, as in the minds of most individual citizens, the concept of a plan for improved health services tends to be based on a single factor -- cost. Frequently attached to this idea is one of the most widespread fallacies of our time --

going creation of our general civil and the maintenance of his standards.

This institution lends much towards an increasement of [illegible] of general Practice in general hospitals, and will continue to do the same in helping the general practitioner to obtain the [illegible] necessary qualifications. We believe that contact with a [illegible] medical school plays a significant part in maintaining and elevating quality of care. The concept of a department of General Practice is different from that of an open hospital, and is as applicable to a teaching hospital as to any other.

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SAME OR SIMILAR [illegible] IN MALTA AND ELSEWHERE

In the minds of political [illegible], as in the minds of most [illegible] [illegible], the concept of a [illegible] [illegible] [illegible] a single [illegible] [illegible]. [illegible] is one of the most [illegible] [illegible] at our time

the concept of government as a creative source of funds.

This Division submits that in reality three factors are involved in any health plan -- cost of service, availability of service, and quality of service. We submit also that any government or political party should be honest enough to spell this out for the Canadian people, and responsible enough to show clearly where the money has to come from.

The cost of service cannot be evaded; but it can, by the application of techniques of efficient insurance and equitable taxation, be equalized.

Insurance equalizes by accumulating premiums in years of health to cover the cost of years of illness, and by collecting from a large group enough to pay for those few members who are actually ill. Insurance, in other words, puts money away for a rainy day. In addition, insurance, at a very small increase in cost, can provide a waiver of premium which will maintain coverage in the event of death or disability of the wage-earner of the family.

Taxation equalizes such costs between low and high, private and corporate incomes, in the sense of placing a fairer share of public burdens on those shoulders better able to carry them.

The availability of care depends on the total numbers of physicians and paramedical personnel, on their geographical distribution, and on their proportional distribution among the various branches of their professions. Considerations of hours of work, and in some instances of efficiency, also play a part in

[illegible] of government as a possible means of [illegible].

Four [illegible] stand out in regard to [illegible] these factors are [illegible] in any health plan: cost of service, availability of service, [illegible] of [illegible]. We submit also that any government [illegible] should be [illegible] to [illegible] for the Canadian people, and reasonable enough to show clearly [illegible].

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availability.

The quality of care is an intangible, but one to which the medical profession has been dedicated in many practical ways. It is a theme which runs throughout this brief. The Division feels that it deserves to be not only encouraged but rewarded.

We believe that the medical profession must remain the provider of medical service for the general population, although some special groups may continue to be cared for under special auspices.

We believe that cost is best provided for by the payment of premiums into an insurance fund. We call on government to pay the premiums of less fortunate citizens, commonly referred to as medically indigent, and to consider the subsidization of the premium for some others so as to bring extended benefits within the reach of the large majority of the population without depriving them of the dignity and self-respect of paying for themselves.

We believe nevertheless that the provision of these insurance arrangements must remain within the hands of private concerns. Such concerns must publish balance sheets, and account for a direct relationship between income and expenditure of funds. Government monies, however, are not so easily accounted for; much income is lumped into Consolidated Revenues, various public needs compete with each other for the tax dollar, money may be borrowed from Peter's fund to cover Paul's deficit, and electoral carrots may be offered at suitable times. Nor does history credit government administration

availability.

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with unsurpassable efficiency, nor with concern for the small problems of the individual.

We believe also that the full cost of medical care should be paid for some citizens, but not for all. The relationship between patient and doctor is a special one; it can be discussed in the abstract when one is well, but theories are generally discarded when one is ill. The direct responsibility between the patient and his family on the one hand, and the doctor and his associates on the other, ensures a mutual interest which should not be underestimated nor lightly done away with. We favour, therefore, a reimbursement or indemnity role for the insurer, outside that relationship.

We believe that government should assist the health professions in their efforts to improve availability of their services, in accordance with the recommendations previously made in this brief. Quality of service will be maintained by the established systems of education, accreditation, self-discipline, and review within the professions, as long as conditions of work are attractive and happy. But unless constructive measures are undertaken to improve availability of service for the future, no manipulation of cost factors will provide the health care Canada will need.

We believe, therefore, that we should build for the future on the foundation of what we have; because what we have, for all its faults, brings better health care to more people than most countries have ever been able to provide, and brings patients and doctors to this continent from all over the world.

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We believe, therefore, that we should build for the future on the foundation of what we have. Despite what we have, for all its faults, [illegible] flexible to provide, and human problems and [illegible] to [illegible] the work.

We believe that government should dedicate every effort to the provision of employment, and of a better standard of living, for every possible Canadian, so that each can have the dignity and self-respect of paying for his own needs.

Finally, we submit that the future of Canadian health care is in the hands, not of those who by their present stake in it stand to gain or lose by any plan which may be introduced, but of those uncommitted Canadian students who in coming years will exercise their free choice of a career. If the government, and the people, do not achieve a plan which will draw them into the health professions, then an immeasurable tragedy will have been added to the history of the free and democratic world.

THE CHAIRMAN: Thank you very much, Dr. Goldbloom, and I may say that your brief, covering as it does, a discussion of the principles, could be very valuable to us.

There are, as you may appreciate, certain areas, certain topics that we may wish further information on, and individual Commissioners will put questions as the subject appears to them.

You speak of shortages in the sense of availability of personnel. What is the actual situation in the Province of Quebec as a whole so far as the number of practicing physicians is concerned?

DR. GOLDBLOOM: That is covered in our brief, sir, in terms of numbers we have in the province. We have registered 6,129 physicians. We have some of

these registered in the province who are actually studying, or otherwise practising outside the province, so that we have 5,920 who are actually functioning. These are over-concentrated in terms of numbers in the metropolitan area. Greater Montreal is fifty-one per cent, and this gives a ratio of one to 625, leaving a ratio of one to more than one thousand for the rest of the province.

THE CHAIRMAN: I suppose that ratio becomes less favourable as you move further away from Montreal, or Quebec?

DR. GOLDBLOOM: Yes, sir, it does. There are certain other centres, Sherbrooke, Chicoutimi, Trois Rivieres, where there are concentrations of doctors, and these centres attract patients from the surrounding areas, so that in actual fact the utilization of physicians' time is not as different in the outlying areas of the province as it is in the metropolitan areas.

THE CHAIRMAN: Well, that is what I was trying to come to, is whether there was a distinctive variation in the availability of service in the rural areas as compared with your metropolitan areas.

DR. GOLDBLOOM: In going around the province and meeting with the doctors in the different areas, we have had the distinct impression that the utilization of a physician's time is about the same wherever the physician exercises his profession.

THE CHAIRMAN: Well now, there is, I suppose, a distinction between availability and utilization. What about on the point of availability, and that

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is availability of the doctor and, of course, the need for the doctor in the rural area. Is that being sufficiently met at the present time?

DR. GOLDBLOOM: No, sir, it is not, but then neither is the availability of the doctor in relation to the need for his services in the metropolitan area. There are people in the metropolitan area who find it difficult to get a doctor available to them, even though the numbers are large. It depends partly on the demands as well as the needs. Demands are more highly developed in a metropolitan area. People are more aware of the services available to them, and make more call on them. The availability is a problem wherever we go.

The City of Montreal is a very large and wide-spread city, and in the outlying areas of the city doctors in the field of medicine have not found it to their advantage to travel these long distances. This creates a problem in utilization of the doctor's time.

THE CHAIRMAN: To what extent has the idea of group practice caught on in Quebec, and how much of it -- what is the proportion, or what use is made of this type of practice?

DR. GOLDBLOOM: In answering that question, Mr. Chairman, I would have to say that group practice is a question of degree. The group practice in the sense of an organized economic unit has not caught on in this province to any appreciable extent. On the other hand, physicians will organize themselves into a group for the exchange of coverage of night calls and weekend calls, so that the doctor may have some rest and

relaxation, and the population will be covered as far as medical services are concerned.

THE CHAIRMAN: Does that apply also in the rural areas?

DR. GOLDBLOOM: It does to some extent, Mr. Chairman. It depends upon the numbers of doctors available. It certainly does in general practice. I think that we can say with confidence that the attitude of the medical profession throughout the province is that if the doctor, as he necessarily must at certain times, feels the need of a rest from his duties, that he does not leave his practice uncovered.

THE CHAIRMAN: Well, that would be a sporadic effort I take it. It would be just to cover a temporary situation?

DR. GOLDBLOOM: Yes, sir, and sometimes it is organized on a regular rotation basis.

THE CHAIRMAN: Has the Quebec Division of the Canadian Medical Association given any thought to encouraging the development of group practice as a means of conserving medical manpower?

DR. GOLDBLOOM: As a Division, no, we have not given this specific consideration.

THE CHAIRMAN: Have you any views on whether the use of the group practice method would, in fact, result in saving medical manpower, or perhaps putting it another way, enabling the present manpower to do more?

DR. GOLDBLOOM: It would be our view, sir, that there are definite advantages in this. I think

population, and the population will be larger as far as medical services are concerned.

MR. CHAMBERS: Does that apply also to the rural areas?

DR. GOODWIN: It does to some extent.

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DR. GOODWIN: Yes, sir, and sometimes it is organized on a regular rotation basis.

THE CHAIRMAN: Do the Ontario Division of the Canadian Medical Association giveen any thought to encouraging the development of group practice as a means of conserving medical manpower?

DR. GOODWIN: As a division, no, we have not gone into specific consideration.

THE CHAIRMAN: Have you any idea as whether the use of the group practice method would, in fact, result in saving medical manpower, or perhaps putting it another way, enabling the present manpower to do more?

DR. GOODWIN: It would be my view that there are definite advantages in that. I think

that I should point out to you that the attitude of the population towards the organization of medical practice has an influence on how medical practice is organized, and that where attempts have been made in this province to organize groups, that people have felt that this was a less personal method of medical care, and that such groups have frequently broken up because they were not accepted by the public.

THE CHAIRMAN: I am going to jump to something else altogether. On page 17 at the top of the page I am referring you, on page 16 you have been discussing and recommending the use of the insurance principle, and you say:

> "We believe that cost is best provided for by the payment of premiums into an insurance fund.",

and then you go on to say that:

> "We call on government to pay the premiums of less fortunate citizens, commonly referred to as medically indigent, and to consider the subsidization of the general premium", etcetera.

In relation to "the large majority of the population

> without depriving them of the dignity and self-respect of paying for themselves."

DR. GOLDBLOOM: Mr. Chairman, if I may interrupt you, sir, we found that this didn't accurately express our thinking when we re-read it, and we made a slight modification in the second line on page 17.

THE CHAIRMAN: You didn't use the word

that I [illegible] on the [illegible] the [illegible] population towards the organization of medical [illegible] has an influence on how medical practice is organized, and that where attempts have been made in this [illegible] to organize groups, that people have felt that this was a less personal method of medical care, and that such groups have frequently broken up because they were not accepted by the public.

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In relation to "the large majority of the population [illegible] depriving them of the dignity and self respect of paying for themselves."

DR. [illegible]: Mr. Chairman, if I may [illegible]

THE CHAIRMAN: You clearly use the word

"general"?

DR. GOLDBLOOM: Yes, we used "premium for some others".

COMMISSIONER McCUTCHEON: Not for the population as a whole?

DR. GOLDBLOOM: No, this was loose phraseology when we wrote it.

THE CHAIRMAN: I wondered what the significance of it was. It changes the tone of the paragraph quite a lot, but taking it as you read it, and as you say you want us to accept it, when you speak of the government helping certain citizens without depriving them of the dignity and self-respect of paying for themselves, are you thinking there of some form of means test that might be adopted and which would not have the so-called undignified result that some people attribute to a means test?

DR. GOLDBLOOM: Yes, sir. We felt that if people are going to be helped by government, that they have to be identified in some way, and we want to submit to you, sir, that a means test, properly applied by people experienced in social service work, is a professional confidence, and is not a public disclosure.

THE CHAIRMAN: Having been identified by such a procedure, how would they, how would such a person identify himself to a medical practitioner in order to get the service if that was confidential as between the potential patient and the interviewer?

DR. GOLDBLOOM: We are talking about two categories here. If we think about the medical indigent --

THE CHAIRMAN: Medical indigent?

DR. GOLDBLOOM: Medical indigents would have their premium paid for them by the government.

THE CHAIRMAN: If you don't mind, those are those who are in receipt of social assistance?

DR. GOLDBLOOM: Yes, sir.

THE CHAIRMAN: Do you call them medical indigents?

DR. GOLDBLOOM: We make that term a little broader than saying indigent. There are a large number of families who are known to various social assistance agencies in the community, and these families should be recommended for such social assitance even though there may be some income, they need some kind of assistance and they should be recommended to the government and have their premiums paid for them. They would be identified to the physician in the least conspicuous way possible. Each person who has an insurance policy under the plan which we propose could have a card stating he is in this insurance plan. Then you would identify only by code number or letter, not by any other distinguishing mark, which would tell the doctor this is a person not paying his own way.

THE CHAIRMAN: The doctor wouldn't know whether or not the patient was, in fact, paying his own premium?

DR. GOLDBLOOM: Yes, sir, in this case the doctor would know because the code would identify the person who wasn't paying his own premium and who wouldn't be considered directly responsible to the doctor

for the cost of his medical care.

THE CHAIRMAN: Perhaps I am not understanding you and you are not understanding me. You are going to have an insurance principle?

DR. GOLDBLOOM: Yes, sir.

THE CHAIRMAN: The person who is able to pay the premium will get some form of identification, a card or something, from the insurance company, from the insurer to show the doctor?

DR. GOLDBLOOM: Yes, sir -- not necessarily to show the doctor. He doesn't have to, but he would have identification which would be used for any situation that would arise in relation to his insurance coverage. He would have a registration number and correspondence written to him would carry this registration number and so on.

THE CHAIRMAN: If I follow you there, you want this on an indemnity, reimbursement or indemnity basis and therefore, I don't see this identification. None of the doctors are concerned whether he has insurance or not. He pays the doctor's bill and he goes to his insurance company and gets reimbursed?

DR. GOLDBLOOM: Yes, sir, that is probably true.

THE CHAIRMAN: So that the only person who would need a card would be the indigent?

DR. GOLDBLOOM: So far as the doctor is concerned, that is correct, sir.

THE CHAIRMAN: What significance are you putting on the code number or something on the card?

for the cost of his medical care.

THE CHAIRMAN: Perhaps I am not answering you and you are not understanding me. You are going to have an insurance protection.

DR. GOLDSBOROUGH: Yes, sir.

THE CHAIRMAN: The person who is able to pay the premium will get some form of identification, a card or something, from the insurance company, from the insurer to show the doctor.

DR. GOLDSBOROUGH: Yes, sir -- not necessarily to show the doctor. He doesn't have to, but he would have identification which would be used for any situation that would arise in relation to his insurance coverage. He would have a registration number and correspondence written to him would carry this registration number and so on.

THE CHAIRMAN: If I follow you there, you want this on an indemnity, reimbursement or indemnity basis and therefore, I don't see this identification. Some of the doctors are concerned whether he has insurance or not. He pays the doctor's bill and he goes to his insurance company and gets reimbursed.

DR. GOLDSBOROUGH: Yes, sir, that is probably true.

THE CHAIRMAN: So that the only person who would need a card would be the indigent?

DR. GOLDSBOROUGH: As far as the doctor is concerned, that is correct, sir.

THE CHAIRMAN: What significance are you placing on the code number or something on the card.

DR. GOLDBLOOM: If a situation arose in which the person entered into some discussion with the doctor about it and the doctor wanted to have further information about the insurance situation, there would be a number. If it is necessary to define people it should be done in the least conspicuous way possible. That is the principle we are trying to say.

THE CHAIRMAN: If I understand you correctly and correct me if I am wrong, it is only somebody who is not prepared himself to pay the doctor who would have to have any identification through which the doctor would be paid from another source.

DR. GOLDBLOOM: Yes, that is correct, sir.

THE CHAIRMAN: You say you would prefer, going on in the middle of page 17, we favour therefore, a reimbursement or indemnity role for the insured outside that relationship. Will you explain that, Dr. Goldbloom?

DR. GOLDBLOOM: Yes, sir, I would be glad to. We think there are two relations involved here, the relationship between the patient and the physician and the relationship between the patient and the insuring company. The relationship between the patient and the physician should be preserved that they should have a sense of mutual responsibility.

THE CHAIRMAN: This is insofar as the professinnal aspect is concerned?

DR. GOLDBLOOM: That is correct.

THE CHAIRMAN: The treatment aspect or the diagnostic feature, whatever it is?

DR. GOLDBLOOM: Yes, we feel the

DR. GOLDSMITH: If a situation arose in which the person endorsed then some disagreement with the doctor about it and the doctor wanted to have further information about the insurance situation, there would be a number. It is necessary to define people it would be done in the least contentious way possible. That is the principle we are trying to set.

THE CHAIRMAN: If I understand you correctly and correct me if I am wrong, it is only somebody who is not prepared himself to pay the doctor who would have to have any identification through which the doctor would be paid from another source.

DR. GOLDSMITH: Yes, that is correct, sir.

THE CHAIRMAN: You say you would prefer going on in the middle of page 17, we favour the idea of a reimbursement or indemnity role for the insured situation that relationship. Will you explain that, Dr. Goldsmith?

DR. GOLDSMITH: Yes, sir, I would be glad to. We think there are two relations involved here, the relationship between the patient and the physician and the relationship between the patient and the insuring company. The relationship between the patient and the physician should be preserved over they should have a sense of mutual responsibility

THE CHAIRMAN: Also an insular as the contractional cannot be consummate.

DR. GOLDSMITH: Make a contract.

THE CHAIRMAN: Are the government agents or the statutorily assuming whatever it is?

DR. GOLDSMITH: Yes, we feel the

physician should have no conflict of interest as far as responsibility. His responsibility should be exclusively to the patient and that patient should be responsible for looking after the doctor insofar as his means allow him. Each person should be expected to stand on his own feet and look after his own obligations. Then the patient would have an opportunity to insure himself to equalize the cost of his medical care, and this should be on a reimbursement basis which would reimburse a substantial proportion, but not the total, of his medical costs.

THE CHAIRMAN: Why not the total if he can find an insurer who is willing to do it?

DR. GOLDBLOOM: We are talking here, sir, about trying to establish a plan which would be accessible to large groups of the population. If we try to cover every medical act at its full cost, we arrive at a cost, and therefore a premium which is a very large one and which becomes prohibitive to a lot of people. We would rather try to cover a portion of it and try to get that proportion in a way that it would leave not an excessive burden of balance of payments for those families who don't have large means, but at the same time not require a very large premium so that people who would want voluntarily to insure themselves under such a scheme, and we hope it would be voluntary ....

THE CHAIRMAN: This is the co-insurance principle you want introduced?

MR. GOLDBLOOM: Yes.

THE CHAIRMAN: Would you have any

physician should have no conflict of interest so far as responsibility. His responsibility should be exclusively to the patient and that patient should be responsible for looking after the doctor treating an his behalf of him. Each person should be expected to stand on his own feet and look after his own confidence. Then the patient would have an opportunity to insure himself to equalize the cost of his medical care, and this should be on a reimbursement basis which would reimburse a substantial proportion, but not the total, of his medical costs.

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THE CHAIRMAN: This is the co-insurance option? You want that option?

MR. GOLDBLOOM: Yes.

THE CHAIRMAN: Would you have an

objection to anyone who felt he would like to pay this large premium to cover himself completely?

DR. GOLDBLOOM: I see no objection if that person has the means.

THE CHAIRMAN: Nothing wrong with the principle.

DR. GOLDBLOOM: To take out a further policy to ensure the balance, that is his privilege, by all means.

THE CHAIRMAN: The mere fact that the patient may be able to exclude himself from any personal responsibilities is not of any significance provided he is able to pay for it?

DR. GOLDBLOOM: That is right, sir.

THE CHAIRMAN: Then, I take it in that way you attach no importance to the patient making a contribution, a personal contribution toward his own cost of illness?

DR. GOLDBLOOM: Not to the technicalities of payment, no, sir, not by any means.

THE CHAIRMAN: I am not talking about payment, the principle it is good that I should pay a percentage of my personal health costs?

DR. GOLDBLOOM: That is a very important point, sir, on which we have tried to enlighten ourselves by consulting some of our psychiatric bretheren. It is very hard to try and reach a full and clear understanding of what the psychiatric role of payment is in the relationship between doctor and patient.

THE CHAIRMAN: I thought I deducted

objection to anyone who could be really like to put this

that person has the means.

policy to ensure the balance, that is his privilege, by all means.

THE CHAIRMAN: The more fact that the patient may be able to exclude himself from any personal responsibilities is not of any significance provided he is able to pay for it?

DR. GOODLUCK: Just is right, sir.

THE CHAIRMAN. Then, I take it in that way you attach no importance to the patient making a contribution - personal contribution towards the cost of illness?

of payment, no, sir, not by any means.

THE CHAIRMAN: I am just balancing about paying, the principle it is good that I should pay a percentage or my personal health contribution

point, sir, on which we have tried to distinguish ourselves by commenting upon our probability insurance. It is very hard to try and assess a fair and clear on ex-

THE CHAIRMAN. I understand deferred

from what you said previously you did sense there was some value in patient A contributing ten, or five or twenty per cent towards his medical cost.

DR. GOLDBLOOM: We do feel that, sir. We feel what you get for nothing is worth nothing.

THE CHAIRMAN: Therefore, a man wishes to pay a little higher premium and cover himself exclusively with more money that would depart from the principle?

DR. GOLDBLOOM: I can't conceive of a very large proportion of the population doing this.

THE CHAIRMAN: Even a small proportion.

DR. GOLDBLOOM: A person who decides this, who is very aware of the value of money, sir, not that everyone is not, money means something very special to a person that goes that far we don't feel we can eliminate all elements of risk from our lives. We feel illness is a risk and we recognize it as such.

THE CHAIRMAN: That is the first phase. What is the second phase you said was involved in this sentence: We favour the reimbursement or indemnity role for the insured outside that relationship?

DR. GOLDBLOOM: The second phase, sir, is the relationship between the patient and the insuring company, and this being conceived on a basis of a partial reimbursement would mean that where a person was medically indigent and wasn't paying a cent, where a physician seeing such a patient would send on behalf of that patient directly to the insuring company, that the handling of the payment in this case would be different,

[illegible]

some value in patient's contributing ten or five or twenty per cent towards his medical cost.

DR. GOLDBLOOM: We do feel that, sir, We feel what you get for nothing is worth nothing.

THE CHAIRMAN: Therefore, a man wishes to pay a little higher premium and cover himself ex-ctuatively with more money that would depart from the [illegible].

DR. GOLDBLOOM: I can't conceive of a very large proportion of the population doing this.

THE CHAIRMAN: Even a small proportion.

DR. GOLDBLOOM: A person who decides this, who is very aware of the value of money, sir, not that everyone is so, money means something very essential to a person that goes that far; we don't feel we can eliminate all elements of risk from our lives. We feel illness is a risk and we recognize it as such.

THE CHAIRMAN: That is the first phase. What is the second phase you said was involved in this sentence: Is there the relationship or community role for the insured outside that relationship?

DR. GOLDBLOOM: The second phase, sir, is the relationship between the patient and the insuring company, and this being conceived on a basis of a partial reimbursement would mean that where a person was medically indigent and wasn't paying a cent, where a physician seeing such a patient would act on behalf of that person directly to the insurance company, that the [illegible] of the payment in this case would be a [illegible],

that the insuring company would send the payment directly to the doctor and the payment would represent the reimbursable portion, which therefore represents the contribution on the part of the physician to the care of the indigent, which has been the principle of the medical profession for a long, long time.

THE CHAIRMAN: What is the attitude of the Quebec Division of the Canadian Medical Association towards the medically sponsored insurance programme such as the programmes we heard about in the Atlantic Provinces, Manitoba Medical and so forth. Have you any such programme, doctor sponsored programme, in the Province of Quebec?

DR. GOLDBLOOM: We have programmes in the Province of Quebec which have medical sponsorship to some degree.

THE CHAIRMAN: I mean, I am putting the question in relation to those specially doctor sponsored programmes.

DR. GOLDBLOOM: No, sir, we don't have a doctor sponsored plan comparable to the Maritime Plan.

THE CHAIRMAN: Or the Ontario Medical?

DR. GOLDBLOOM: No, sir.

THE CHAIRMAN: Has the Quebec Division an opinion to express on the desirability or undesirability of such a plan?

DR. GOLDBLOOM: We feel, sir, that the medical profession has in the past offered such plans and service to the population and that the present tenor of the public's attitude is such that these don't seem

that the insuring company would send the payment directly to the doctor and the patient would represent the [illegible] contribution on the part of the physician to the cost of the illegal, which has been the principle of the medical [illegible].

THE CHAIRMAN: What is the attitude of the Quebec Division of the Canadian Medical Association towards the medically sponsored insurance programme such as the programme we need about in the Atlantic Provinces, Manitoba Medical and so forth. Have you a [illegible] programme, doctor sponsored programme in the Province of Quebec?

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THE CHAIRMAN: I mean, I am putting the question in relation to those specifically doctor sponsored programmes.

DR. GOLDBLOOM: No, sir, we don't have a doctor sponsored plan comparable to the Manitoba Plan.

THE CHAIRMAN: Or the Ontario Medicare?

DR. GOLDBLOOM: No, sir.

THE CHAIRMAN: Has the Quebec Division an opinion to express on the desirability or undesirability of such a plan?

DR. GOLDBLOOM: We feel, sir, that the medical profession has in the past offered good plans and service to the population and that the present tempo of the public's attitude is such that there doesn't seem

to answer the full needs. We feel that in order to expand plans, if they are to be done under medical sponsorship that this will require considerable effort on the part of the medical profession, and we feel that the business of the physician is treating patients and the business of the insurance companies is handling insurance and the business of government is supervision and regulating, and we feel, therefore, that it is better rather than pushing for further development of doctors' sponsorship in plans, that the doctor concentrate on looking after the patients and that the patient insure himself outside that relationship.

THE CHAIRMAN: Thank you very much, Doctor. Any questions Dr. Baltzan?

COMMISSIONER BALTZAN: Dr. Goldbloom, and gentlemen, I consider your presentation as a very clear one and a very broad spectrum one. I am going to hurry my questions because we have very limited time.

I see you definitely encourage the institution of the Department of General Practice in the general hospitals?

DR. GOLDBLOOM: Yes, sir.

COMMISSIONER BALTZAN: We heard yesterday there is considerable difficulty on the part of a large proportion of men in general practice to obtain appointments in general hospitals. Is that really the case?

DR. GOLDBLOOM: Yes, sir, I think that there is a fair proportion of truth in this, that there is difficulty for general physicians to have access to hospitals, especially in the large metropolitan areas.

to answer the full means. We feel that in order to expand plans, if they are to be done under medical [illegible]

on the part of the medical profession, and we feel that the business of the physician is treating patients and the business of the insurance companies is handling insurance and the business of government is supervision and regulating, and we feel, therefore, that it is better rather than passing for further development of doctors sponsorship in plans, that the doctors concentrate on looking after the patients and that the patients insure themself against that relationship.

THE CHAIRMAN: Thank you very much.

[illegible]

and gentlemen, I consider your presentation as a very clear one and a very broad approach one. I am going to hurry my questions because we have very limited time.

I see you definitely encourage the institution of the government of course. Therefore in the general hospitals?

Dr. GOTTESMAN: Yes, sir.

CONSCRIPTION MEMBER: We heard yesterday there is considerable difficulty on the part of a large proportion of men in general practice to obtain appointments in general hospitals. Is that really the case?

DR. GOTTESMAN: Yes, sir, I think that there is a fair proportion, of which is true, where there is difficulty for general practitioners to have access to hospitals, as a result in the large metropolitan areas.

This is not true of the rural areas. The general physician forms the major proportion of the medical staff of the smaller hospitals outside the metropolitan areas.

COMMISSIONER BALTZAN: But in principle, you are encouraging and trying to remedy that situation here?

DR. GOLDBLOOM: Yes, sir, we are.

COMMISSIONER BALTZAN: There is actually no overt objection to the institution of the principle?

DR. GOLDBLOOM: No, sir, we said in our brief that contact with the hospital milieu has a beneficial effect on any physician. We feel, as far as teaching hospitals are concerned, we feel that a student should not go through his medical education without having contact with the general physician and know what general practice is like.

COMMISSIONER BALTZAN: Yes, thank you very much.

THE CHAIRMAN: For a moment, pardon me. We heard yesterday and we only put it to you for clarification purposes, in the Montreal area, this is where your greatest concentration of medical practitioners are, fifty-one per cent, it is right here, that these general practitioners were agitating for the right to have some beds alloted in the hospitals and that after considerable talk they succeeded in getting sixteen out of one thousand. Is this the situation that does exist or were we given a situation, were we given a distorted situation?

DR. GOLDBLOOM: No, sir, I would hardly

[illegible]

[illegible] larger forms the major proportion of the medical staff of the smaller hospitals circumvent the metropolitan areas.

[illegible]

You are encouraging and trying to remedy that situation here?

MR. COLDEBROOK: Yes, sir, we are.

COMMISSIONER MARTIN: There is actually no overt objection to the institution of the preceptorship?

DR. SCHOLDBERG: No, sir, we feel in our belief that contact with the hospital milieu has a beneficial effect on any physician. We feel, so far as teaching hospitals are concerned, we feel that a student should not go through his medical education without having contact with the general population and know what general practice is like.

COMMISSIONER MARTIN: Yes, thank you very much.

THE CHAIRMAN: Doctor Rousek, please.

We heard yesterday and we only put it to you for clarification purposes, in the Montgomery area, that is where your greatest concentration of medical practitioners are, fifty-one per cent. Is it right here, that there general practitioners were satisfying for the right to have some best alleged in the hospitals and that either considerable talk they succeeded in getting someone out of one thousand. In other the situation that even either or were we given a situation, where we have a [illegible]

[illegible]

DR. ROUSEK: No, sir, I would hardly

wish to imply a distorted situation was presented to you by the Association of General Practitioners, who have done a very careful survey of the conditions under which their members work, and I would certainly accept their statistics. We wouldn't be satisfied with this, but we wouldn't want to go to the opposite extreme and open every hospital to every physician. I think we should point out to you as it has already been pointed out to you that the organization within the medical profession, for the promotion and determination of qualifications are of relatively recent origin. The College of Physicians and Surgeons began in the province to certify specialists in 1948. The College of General Practice dates from 1954. We feel this is on both sides a process of gradual education. We would like to do our part in speeding up this educatinnal process, that is standarize qualifications of every general physician so he will meet the standards which are required and should be retained. The hospital, on the other hand, educate the hospitals so that they can feel that the general physician is a worthwhile member of their staff and can make a contribution.

THE CHAIRMAN: Dr. Goldbloom, this is perhaps an errant thought that just goes through your mind from time to time. A doctor graduates from a recognized medical school. He does his required period of internship. Is he not then qualified to practice medicine and to go into a hospital?

DR. GOLDBLOOM: He is qualified, sir. He has certain responsibility to himself and to his

wish to imply a distortion situation was presented to us by the Association of General Practitioners, we have done a very careful survey of the conditions under which their members work, and I would certainly accept their statistics. We wouldn't be satisfied with them, nor we wouldn't want to go to the opposite extreme and open every hospital to every physician. I might as well point out to you as it has already been pointed out to you that the organization within the medical profession, for the promotion and determination of qualifications are of relatively recent origin. The College of Physicians and Surgeons began in the province to certify specialists in 1946. The College of General Practitioners from 1954. We feel this is an both a process of general education. We would like to see our part in speeding up this educational process, that is provide the qualifications of every general practitioner so he will meet the standards which are required and soonly be restricted. The hospital, on the other hand, should the hospitals so that they can feel that the general physician is a responsible member of their staff and can make a

The chairman: Dr. Patterson, this is perhaps an overall question that just came through from time to time. A doctor associates himself recognized medical school. He does his required period of internship. Is he not then qualified to practice medicine and do his own thing?

Dr. Patterson: No, no, sir. He has certain rights within the hospital to do so. If and if the

patients and to his profession to continue his education. Medicine has been moving ahead so rapidly in the last two decades that he cannot graduate from medical school and rest on his laurels and remain a fit doctor to staff an institution.

THE CHAIRMAN: I haven't had him sit around. He has just come out.

DR. GOLDBLOOM: Yes, sir.

THE CHAIRMAN: If there are not beds available to the general practitioner how does he practice medicine?

DR. GOLDBLOOM: It becomes very difficult for him, sir, and that is why we have put that into our brief, and why I read into the record our section on our support for the general practitioner.

THE CHAIRMAN: How does your support go beyond the expression in the statement of principle in relation to sixteen beds in a thousand in a hospital being allocated to the general practitioner?

DR. GOLDBLOOM: Well, sir, I think that we can say that we are in a situation in which this has not been sufficiently our concern and has not come sufficiently to our attention until now. We have directed our committee on general practice to undertake the study of this situation and we are expecting a contribution from them on which we can base recommendations which we will like to pass on to these institutions concerned. We have no authority over hospitals, sir.

THE CHAIRMAN: I don't want to be just speaking, leave the impression I am just speaking to be

patients and to the protection of consumers in medicine. Medicine has been moving away so rapidly in the last two decades that he cannot produce specialist report and rest on his laurels and remain a life director in such an institution.

THE CHAIRMAN: I haven't had time to read. He has just come out.

DR. GOLDBLOOM: Very sorry.

THE CHAIRMAN: If there are not books available to the general practitioner how does he practise medicine?

DR. GOLDBLOOM. It becomes very difficult for him, sir, and that is why we have put this into our brief, and why I read into the record our position on our support for the general practitioner.

THE CHAIRMAN: Now does your support go beyond the expression in the statement of principle in relation to attempts made in a thousand ways to keep being allocated to the general practitioner?

DR. GOLDBLOOM: Well, sir, I think that we can say that we are in a situation in which we have not been sufficiently our concern and has not come sufficiently to our attention until now. We have discussed our commitment to general practice so that only of this discussion has we run across a situation from time to which we can see the consequences and we will like to pass on to these institutions concerned. We have to support our specialists, sir.

MR. CHAIRMAN: I hope we do not spend time, leave the impression I am just speaking to i

embarrassing, but you say there is a shortage of students. You make the recommendation that you want this Commission, by some process or another, to accelerate the recruitment of young men and women wishing to study medicine, and is there an indistinct impression left that only the specialist is really going to get a good break?

DR. GOLDBLOOM: Sir, that is not the attitude of this Association, and if we return to the person that you have just postulated who is graduated from a medical school and had his training in a hospital, we would feel he should have the right to attach himself to a hospital.

THE CHAIRMAN: He had his training in a hospital?

DR. GOLDBLOOM: Yes, sir, but in the meantime there are doctors who have practised without the benefits, or perhaps, even with the benefits, but who haven't maintained their continuing education and their equipment. If we are talking about those doctors -- we can't simply say we will take every doctor in the hospital. We have a problem of hospital beds which affects every physician. This couldn't be corrected by fiat, we simply bring more doctors into the hospital. We have to do it on a gradual basis. We have proposed increasing the number of beds. Hand in hand we would want to bring the general physician into the hospital. This is the fault of the past, this has been allowed to occur. I would like to ask Dr. Quintin to say a word about Sherbrooke.

THE CHAIRMAN: Perhaps the statistics

by some process of analysis, to accelerate the development of young men and women wishing to study medicine and is there an institution in which we can be sure that only the specialist is really going to get a good degree?

DR. GOLDFLOOM: Sir, I can at see the activities of these associations, and if we return to the person that you have just questioned who is graduate from a medical school and had his training in a hospital, we would feel he already have the rights to attach himself to a hospital.

THE CHAIRMAN: He had his training in a hospital?

DR. GOLDFLOOM: Yes, sir, but in the meantime there are doctors who have practised without the hospitals, or practices, even with the hospitals, and who have a relationship with commercial institutions and their equipment. If we are talking about these doctors -- we can't simply say we will take every doctor in the hospital. We have a problem of hospital beds which affects every province. This is another or commercial or fact, we already being more doctors than the hospitals. We have to do it on a general basis. We have programs increasing the number of beds. Hard in hand we are going to bring the general practitioner into the hospital. This is the result of the past. This has been allowed to occur. I would like to ask Dr. Goldfloom to say a word about Jewish.

in Sherbrooke might be a little different.

DR. QUINTIN: I would like to explain this is a periphery hospital. If you have this young man I wish you would send him to Sherbrooke. If he comes to us with the qualifications you outlined .....

THE CHAIRMAN: I haven't given him special qualifications. All I have given him is graduation from a medical school.

DR. QUINTIN: That is a definite qualification.

THE CHAIRMAN: Registration, and he is now on the road to practice medicine.

DR. QUINTIN: He is qualified. He would be assigned to the general practice and would be considered by the credentials committee according to his various abilities as he shows them. He would be given a profile, what we call the amos profile, based on one well known in the Army, the Puhlems system, a well recognized one. A is for anaesthetics; M is medicine; O is obstetrics and S is for surgery. Let us say he is a man who did his training in surgery. He would probably be given a category or profile something like this. A 3 -- he is not interested in anaesthetics, so it would be A 3; M 3; O 3, but he may be given S 2 or even S 1 if he is particularly valuable as a surgeon. If, however, he is a general practitioner who is very interested in obstetrics he may be given A 3, M 3, and O 2, so we develop a profile of each man and he will then advance into the area where he is most interested and most qualified. He won't be turned away.

DR. WHITTEN: I would like to explain this is a perfectly regular. If you have this young man I wish you would send him to Winnipeg. He is known to us with the qualifications you outline ....

THE CHAIRMAN: I have to grant him special qualifications. All I have given him is graduation from a medical school.

DR. WHITTEN: That is a worthwhile qualification.

THE CHAIRMAN: Registration, and he is now on the road to practice medicine.

DR. WHITTEN: He is qualified. He would be assigned to the general practice and would be considered by the recommendation committee according to his various abilities as he shows them. He would be given a profile, which we call the ABCD profile, based on one well known in the Army, the Duncan system, a well recognized one. A is for auscultation; M is mechanical; O is observation and S is for surgery. Let us say he is a man who did his training in surgery. He would probably be given a category or profile accordingly like this. A 3 -- he is not throughly auscultation, so it would be A 3: M 3: O 3, and he may be given S 2 or even S 1 if he is particularly valuable as a surgeon. If, however, he is a general practitioner who is very interested in observation he may be given A 3, M 3, and O 2, so we develop a profile of each man and he gets then advance into the area where he is more interested and more qualified. He won't be burned away.

THE CHAIRMAN: Thank you very much, Dr. Quintin. I think we will arise now until two o'clock, gentlemen.

COMMISSIONER BALTZAN: You will have to change Amos to Pamos. You omitted paediatrics.

THE CHAIRMAN: Will it be convenient for you to return at two o'clock?

DR. GOLDBLOOM: Yes, sir.

--- Luncheon adjournment.

--- On resuming at 2:00 p.m.

THE CHAIRMAN: Will you excuse us, gentlemen, for being a few minutes late.

COMMISSIONER BALTZAN: Gentlemen, I am afraid I lost my train of thought since I last saw you, but that is not the first time I missed a train or a boat, and you will be relieved too. I ask for your indulgence for just a minute.

On page 7:

"In addition, most districts lacking a particular speciality are served by visiting consultants from larger centres --"

How is that arranged? Do you have regular visiting teams to the areas, or are they on call?

DR. GOLDBLOOM: It is done on a regular basis, but it is not organized by a medical society necessarily. This is an individual undertaking by a physician who elects to cover areas other than in which he resides.

COMMISSIONER BALTZAN: And this meets the need in this manner?

DR. GOLDBLOOM: It is a limited way of meeting the need.

COMMISSIONER BALTZAN: And do they also at the same time give some instruction in the form of lectures, demonstrations, etcetera?

DR. GOLDBLOOM: They may do so. That is an individual thing.

--- On resuming at 2:10 p.m.

THE CHAIRMAN: Will you excuse me, gentlemen, for being a few minutes late.

I am afraid I lost my train of thought since I asked you, but that is not the first time I missed a train or a boat, and you will believe too. I ask for your indulgence for just a minute.

On page 7:

"In addition, much otherwise having a particular specialist are served by visiting consultants from larger centres. How is that arranged? Do you have regular visiting teams to the areas, or are they on call?

DR. CHAMPION: It is done on a regular basis, but it is not organized by a medical society necessarily. This is an individual undertaking by a obstetrician who elects to cover areas other than in which he resides.

COMMISSIONER LAMBERT: And this means the need in this manner?

DR. CHAMPION: It is a limited way of meeting the need.

COMMISSIONER BALTZAN: And do they also on the same time give some instruction in the form of lectures, demonstrations, otherwise?

DR. CHAMPION: They may do so. That is an individual's training.

COMMISSIONER BALTZAN: My next question, in the same page:

"In the major centres, however, notably in Montreal, specialists are numerous and are commonly consulted directly by the patient without intermediary".

My question is, do you approve of that? Do you consider it good, or is it in conformity with the principles and customs of our North American ways, that is, that the individual has the right to chose to go to a specialist without going through an intermediary?

DR. GOLDBLOOM: In terms of our free choice of a doctor by the patient, we believe this is in accordance with our principles. It is also a fact of medical life in a city of this kind.

COMMISSIONER BALTZAN: I ask that because we had other opinions at other times. A question on page 9, you stress the element of teaching medical students, internes, graduate physicians, nurses, etcetera, etcetera, which is part and parcel of medical services, and under the present conditions, this adds to the cost price of medical services. Would you explain it? It is part and parcel of rendering the hospital services to in-hospital patients?

DR. GOLDBLOOM: Yes, sir, it is considered part of the obligation of a physician who accepts a position in a teaching department or in a hospital.

COMMISSIONER BALTZAN: And that makes for the extra cost in providing hospital services?

DR. GOLDBLOOM: I don't think that it

COMMISSIONER DALTON: My next question, in the same page:

"In the major centres, however, medical, in Montreal, specialists are numerous and are commonly consulted directly by the patient without intermediary".

My question is, do you approve of that? Do you consider it good, or is it in conformity with the principles and customs of our North American ways, that is, that the individual has the right to choose to go to a specialist without going through an intermediary?

DR. GOLDBLOOM: In terms of our free choice of a doctor by the patient, we believe this is in accordance with our principles. It is also a fact of medical life in a city of this kind.

[illegible] we had other opinions at other times. A question on page 5, you stress the element of teaching medical [illegible] clinics, which is part and parcel of medical services, and under the present conditions, this adds to the cost price of medical services. Would you explain it? It is part and parcel of rendering the hospital services to in-hospital patients.

DR. GOLDBLOOM: Yes, sir, it is considered part of the obligation of a physician who accepts a position in a teaching department or in a hospital.

[illegible] for the extra cost in providing hospital services?

DR. GOLDBLOOM: I don't think that is

contributes to the extra cost as far as the patient is concerned. It may contribute indirectly, insofar as a physician has accepted an obligation to give treatment of this kind, and has to make a living at the same time. Perhaps if he devoted himself entirely to practice his fees could be lower, but this is an indirect thing.

COMMISSIONER BALTZAN: But it is part of the health cost budget?

DR. GOLDBLOOM: No, sir, this is not included.

COMMISSIONER BALTZAN: Do these fees come from outside sources, rather than from the hospital budget?

DR. GOLDBLOOM: Well, there you are talking about the people who receive the teaching. We were talking before about those providing the teaching. They are not remunerated and if they are, they are on a full time basis and part of a university budget generally.

COMMISSIONER BALTZAN: My question has to do with these people who are rendering service, but are being learned at the same time, and their salaries, for the most part, and their maintenance, comes out of the hospital budget?

DR. GOLDBLOOM: Yes, sir, that is correct.

COMMISSIONER BALTZAN: Which adds to the total cost of hospital care?

DR. GOLDBLOOM: It could indirectly, sir. If we presume that by requiring that internes and other hospital personnel devote some time to learning as part

contributes to the extra cost as far as the patient is [illegible]

[illegible]

of this kind, and has to make a living at the same time, perhaps if he devoted himself entirely to practice his fees could be lower, but this is an indirect thing.

COMMISSIONER HAMILTON: Put it in part of the health cost budget?

DR. GOLDSTEIN: No, sir, that is not included.

COMMISSIONER HAMILTON: Do these fees come from outside sources, rather than from the hospital budget?

DR. GOLDSTEIN: Well, since you are talking about the people who receive the teaching, we were talking before about those providing the teaching. They are not remunerated and if they are, they are on a full time basis and part of a university budget generally.

COMMISSIONER HAMILTON: So practically speaking, we are to wish these people who are receiving service, but are being learned at the same time, and other salaries, for the most part, and their maintenance, comes out of the hospital budget?

DR. GOLDSTEIN: Yes, sir, that is correct.

COMMISSIONER HAMILTON: Would come to the total cost of hospital care?

DR. GOLDSTEIN: It would increase it, if we presume that by requiring that interns and other hospital personnel devote some time to learning as part

of their occupation, that more of them are necessary to ensure the coverage of patient care.

COMMISSIONER BALTZAN: I shall simply ask a little clarification on page 11:

"The physician in the larger centre is less freely mobile and many factors make practice more time-consuming and less efficient there."

We heard a little bit of that earlier in your presentation. What is that lack of mobility? Is it the traffic, the distance?

DR: GOLDBLOOM: Mostly traffic and distance within the metropolitan area. The distance may not seem very great in comparison with rural distances, but covering eight or ten miles within the metropolitan area, as one sometimes has to do, is extremely time-consuming. In the rural area the doctor makes it quite quickly.

COMMISSIONER BALTZAN: I don't suppose you got down to exact figures, but I know one estimate in a large metropolitan area in the U.S.A., where the average time to get to a house is forty minutes, and forty minutes to get back, and the time to look after the patient takes valuable time. I suppose you haven't broken down the minutes or seconds?

DR. GOLDBLOOM: No, sir.

COMMISSIONER BALTZAN: Well, I have broken them down here, and I am not going to ask you to do anything more.

COMMISSIONER FIRESTONE: If I may turn

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DR. GOLDBLOOM: No, sir.

COMMISSIONER BERTRAM: Well, I have broken them down here, and I am not going to ask you to do anything more.

COMMISSIONER FITZSTOWN: If I may turn

first to page 10, in the section dealing with Health Care of Medically Indigent, you say in the first sentence:

"Not a single district reports major difficulty in the provision of health care to the medically indigent, although imperfections do exist."

Could you elaborate some of those imperfections?

DR. GOLDBLOOM: Well, sir, we went to the various districts and sent questionnaires to all. districts, and we spoke with doctors there and asked them how do the indigents get looked after, and their answers were in rather general terms, and therefore I have to answer you in rather general terms.

They said more or less, well, that is to say where the obligation is presented to the physician to provide the care that the physician provides it. That this does not always cover everything that might be necessary, that might be advisable in such a case, because of things which have been touched on in other discussions, such as drugs, and so on, and they present a problem.

Care of other sorts, ancillary care, physiotherapy, or whatever it may be, may not be available, or if available, at a distance away, and the transportation to reach it may not be possible.

What we imply, sir, is simply that in consulting the membership of this Division we found an expression of goodwill in this regard, and an effort to provide this care as much as was possible.

COMMISSIONER FIRESTONE: You suggested

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Care of other sorts, auxiliary care, physiotherapy, or whatever it may be, may not be available, or if available, at a distance away, and the transportation to reach it may not be possible.

What we imply, sir, is simply that in consulting the membership of this Division we found an appreciation of goodwill in this regard, and an effort to provide this care as much as was possible.

COMMISSIONER ETHERTON: You suggest

that medically indigents are referred to a doctor. Did I understand you correctly?

DR. GOLDBLOOM: It is frequently the case.

COMMISSIONER FIRESTONE: Well, who does the referring to the doctor? How does it work in practice?

DR. GOLDBLOOM: It depends whether we are referring to metropolitan or rural areas. In rural areas generally the population is known to the doctor, and the relationship is a direct one.

COMMISSIONER FIRESTONE: May I just stick to this one question. Therefore, if somebody is medically indigent, or indigent, he would go to the doctor and say: "Doctor, I cannot pay you, I don't feel well." and the doctor would look after him?

DR. GOLDBLOOM: This is our understanding, yes.

COMMISSIONER FIRESTONE: In other words, the doctor subsidizes the indigent and the medically indigent in the rural areas?

DR. GOLDBLOOM: Yes, sir. In the metropolitan areas the social services are much more highly developed, and the social service agencies are frequently the instruments by which the patient and the doctor are brought together. If this is done by a well-organized social agency, they generally have a panel of physicians, who have accepted this responsibility and receive a limited recompense.

In this city we also have an enormous development of out-patient departments in hospitals, and

that medically indigent are referred to a doctor. Do I understand you correctly?

DR. GOLDBLOOM: It is frequently the case.

COMMISSIONER FRANCHOME: Well, who does the referring to the doctor? How does it work in practice?

DR. GOLDBLOOM: It depends whether we are referring to metropolitan or rural areas. In rural areas generally the population is known to the doctor, and the relationship is a direct one.

COMMISSIONER FRANCHOME: May I just stick to this one question. Therefore, if somebody is medically indigent, or indigent, he would go to the doctor and say: "Doctor, I cannot pay you, I don't feel well." and the doctor would look after him?

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COMMISSIONER FRANCHOME: In other words, the doctor substitutes the indigent and the medically indigent in the rural areas?

DR. GOLDBLOOM: Yes, sir. In the metropolitan areas the social services are much more highly developed, and the social service agencies are frequently the intermediaries by which the patient and the doctor are brought together. If this is done by a well-organized social agency, then generally have a panel of physicians, who have accepted this responsibility and receive a limited recompense.

In this city we also have an enormous development of out-patient departments in hospitals, and

patients are referred there by social agencies, by physicians, and by themselves.

COMMISSIONER FIRESTONE: And you have no specific examples in mind when you speak of imperfections? It is just a general observation?

DR. GOLDBLOOM: It is just a general observation, sir.

COMMISSIONER FIRESTONE: On page 13, in paragraph (c), you speak of the possibility of expansion of a faculty of medicine at Sherbrooke, and then you say:

> "....alternatively of the foundation of a sixth faculty of medicine in the province...."

and this apparently is a subject that you wish to be studied, as to where such a faculty should be established?

DR. GOLDBLOOM: Yes, sir.

COMMISSIONER FIRESTONE: Have you any particular location in mind?

DR. GOLDBLOOM: No, sir. I think it would be presumptous on our part to suggest, not being a university body. We have consulted the Deans of the Faculties of Medicine, and asked their opinions. We haven't asked them specifically where. It is our understanding that the University of Sherbrooke intends to start rather moderately, and graduate about twenty-five students when they have their first graduating class, at present estimated for 1971, and that eventually might get up to sixty-five. This is something that we cannot count on, and this is why we propose the alternative of an additional faculty, without making a specific

patients are referred there by social agencies, by physicians, and by themselves.

COMMISSIONER FRESTONE: And you have no specific examples in mind when you speak of imperfections? It is just a general observation?

DR. GOLDBLOOM: It is just a general observation, sir.

On page 12, in paragraph (c), you speak of the possibility of expansion of a faculty of medicine at Sherbrooke, and then you say:

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and this apparently is a subject that you wish to be studied, as to where such a faculty should be established?

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recommendation in that direction. I think that it would be less costly and more efficient to try and expand what we have than to try to start de novo to establish a new faculty.

COMMISSIONER FIRESTONE: Dr. Quintin, would you like to say something about it?

DR. QUINTIN: No, I have no comments.

COMMISSIONER FIRESTONE: Page 16, and the pages following, where you deal with basic consideration in health care planning, you emphasize in the second paragraph that consideration should be given to three factors in any health plan: Cost of service; availability of service, and quality of service.

May I ask you whether we can talk perhaps in terms of principles of the kind of planning that you seem to have in mind, and if my understanding is not quite correct from what I have read, please correct me.

I take it you are first in favour of the principle of pre-payment of medical care?

DR. GOLDBLOOM: That is correct, sir.

COMMISSIONER FIRESTONE: Are you secondly in favour of a comprehensive medical care plan for the Province of Quebec using the term comprehensive in covering all reasonable and appropriate medical care service concerned with physical ill health and mental ill health?

DR. GOLDBLOOM: Yes, sir, as we expressed to the Commission this morning, we are in favour of the broadest possible coverage for health services. We don't feel that the full cost of these services can easily be

be less costly and more economic to buy and expand when we have time to try to assess or give be established a new facility.

[illegible]

would you like to say something about it?

MR. [illegible]: No, I have no comments.

COMMISSIONER [illegible]: Page 10, and the paragraph following, where you deal with basic consideration in health care planning, you enumerate in the second paragraph that consideration should be given to three factors in any health plan: Cost of services; availability of services, and quality of service.

May I ask you whether we can take perhaps in terms of principles or the kind of planning that you seem to have in mind, and if my understanding is not quite correct from what I have read, please correct me.

I take it you are [illegible] in favour of the principle of pre-payment of medical care?

DR. GOLDBLOOM: That is correct, sir.

COMMISSIONER [illegible]: Are you secondly in favour of a comprehensive medical care plan for the Province of Quebec using the term comprehensive in covering all reasonable and appropriate medical care [illegible] health?

DR. GOLDBLOOM: Yes, sir, as we expressed to the Commission this morning, we are in favour of the greatest possible coverage for health services. We merely fear that the full cost of these services can easily be

borne under a single premium of an insurance type.

COMMISSIONER FIRESTONE: At the moment I am not asking as to how the programme will be financed. I am just trying to understand what you are trying to cover. I understand you have in mind comprehensive coverage in the sense of medical care services provided to the people suffering ill health, physical and mental, is that correct?

DR. GOLDBLOOM: Yes, sir.

COMMISSIONER FIRESTONE: You also have in mind a plan that, and this is the third principle, that would be universal, to provide for universal coverage, in the sense of being universally available to everybody?

DR. GOLDBLOOM: Yes, sir.

COMMISSIONER FIRESTONE: And the fourth principle is that you wish to have this universal coverage achieved by voluntary means, is that correct?

DR. GOLDBLOOM: Yes, sir, that is correct.

COMMISSIONER FIRESTONE: So we have those four principles on which you proposed a programme be based?

DR. GOLDBLOOM: Yes.

COMMISSIONER FIRESTONE: Then you go on on the method of financing this plan, you say that it ought to be financed from two major sources. One, premium payment by those who can pay premiums, and the State paying the premium for those that cannot pay the premiums, is that correct?

DR. GOLDBLOOM: Yes, sir.

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COMMISSIONER FERRIGNONE: At the moment I am not asking as to how the programme will be financed. I am just trying to understand what you are trying to cover. I understand you have in mind comprehensive coverage in the sense of medical care services provided to the people suffering ill health, physical and mental, is that correct?

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principle is that you wish to have such universal coverage achieved by voluntary means, is that correct?

DR. CHARBONNEAU: Yes, sir, that is -

COMMISSIONER FERRIGNONE: So we have those four principles on which you proposed a programme be based?

COMMISSIONER FERRIGNONE: Then you go on on the method of financing this plan, you say that it ought to be financed from two major sources. One, premium payment by those who can pay premiums, and the other paying the premium for those that cannot pay the premiums, is that correct?

DR. CHARBONNEAU: Yes, sir.

COMMISSIONER FIRESTONE: And you say that the State would pay those premiums, taking the money out of general revenue collected through taxes?

DR. GOLDBLOOM: We haven't specified what revenue, sir. We would rather say that if the State is going to collect revenue for this service, that we would like to know what income and what expenditure are in such a fund, rather than put it into general revenue.

COMMISSIONER FIRESTONE: Well, as I read your paragraphs 4 and 5 on page 16, you speak first of insurance payments through premiums, and then in the next paragraph you speak of taxation, and I take it taxation is used to pay, to collect revenue, to pay for the premiums for the indigent and the medically indigent is that correct?

DR. GOLDBLOOM: Yes, sir.

COMMISSIONER FIRESTONE: You then go on in this paragraph on taxation and say that:

> "Taxation equalizes such costs between low and high, private and corporate incomes, in the sense of placing a fairer share of public burdens on those shoulders better able to carry them."

Does this sentence reflect your subscription to the principle that the cost of such a plan should be borne on the basis of the ability to pay?

DR. GOLDBLOOM: Yes, sir. I think necessarily that we would subscribe to such a principle, but there are many forms of taxation, some of which do take into account ability to pay, and others which do not,

CHAIRMAN BRENNAN: And you say that the State would pay these premiums, taking the money

MR. GOLDBLOOM: We haven't specified what revenue, etc. We would rather say that if this State is going to collect revenue for this purpose, that we would like to know what income and what expenditure are in such a fund, rather than not in the general revenue.

COMMISSIONER HINKSTON: Well, as I read your paragraphs 4 and 5 on page 10, you speak first of insurance payments through premiums, and then in the next paragraph you speak of taxation. And I gets in taxation is used to pay, to collect revenue, to pay for the premiums for the indigent and the medically indigent is that correct?

MR. GOLDBLOOM: Yes, sir.

COMMISSIONER HINKSTON: You then go on in this paragraph on taxation and say then,

"Taxation equalizes such costs between low and high, private and corporate incomes, in the cases of placing a fair share of public burdens on those financially better able to carry them."

Does this sentence reflect your concepti-on to the principle that the cost of such a plan should be borne on the basis of the ability to pay?

MR. GOLDBLOOM: Yes, sir. I think I essentially that we would subscribe to such a principle, but there are many forms of taxation, some of which do take into account ability to pay, and others which do not.

and we could foresee that government might choose to apply both principles in deriving revenue for such a fund.

COMMISSIONER FIRESTONE: What would you be in favour of? The principle of ability to pay?

DR. GOLDBLOOM: Largely, yes, sir.

COMMISSIONER FIRESTONE: Well, largely, means you are or you are not?

DR. GOLDBLOOM: Yes, sir, we are in favour of that, sir.

COMMISSIONER FIRESTONE: Thank you. Now, sir, you said earlier when we were discussing the principle of coverage that you had in mind a plan that would be universally available, and you would be interested in seeing as many people as possible covered under the plan on a voluntary basis. We received a submission in Quebec City from L'Association de Sante du Quebec, in which it was recommended to us, a similar plan to yours, but they recommended that the plan should be on a compulsory basis and cover everybody, and when we asked them why, there were a number of reasons, one of which was the premiums payable, by spreading the risk over all people, would be lower per person covered. We asked them further whether they thought that the medical profession of the Province of Quebec would co-operate in such a plan, and they said, they believed they would. What are your views, sir?

DR. GOLDBLOOM: Well, sir, if I may be a little presumptuous, they said more than that. They said that if the medical profession in sufficient numbers didn't co-operate, they would expect the government to

and we could foresee that government might choose to apply both principles in deriving revenue for such a fund.

COMMISSIONER WRIGHTSON: What would you be in favour of? The principle of ability to pay?

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COMMISSIONER WRIGHTSON: Well, largely, means you are or you are not?

Dr. GOLDBLOOM: Yes, sir, we are in favour of that, sir.

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Now, sir, you said earlier when we were discussing the principle of coverage that you had in mind a plan that would be universally available, and you would be interested in seeing as many people as possible covered under the plan on a voluntary basis. We received a submission in Quebec City from L'Association de Santé du Québec, in which it was recommended to us, a similar plan to yours, but they recommended that the plan should be on a compulsory basis and cover everybody, and when we asked them why, there were a number of reasons, one of which was the premium payable, by spreading the risk over all people, would be lower per person covered. We asked them further whether they thought that the medical profession of the Province of Quebec would co-operate in such a plan, and they said, they believed they would. What are your views, sir?

Dr. GOLDBLOOM: Well, sir, if I may be a little presumptuous, they said more than that. They said that if the medical profession in sufficient number didn't co-operate, they would expect the government to

coerce the medical profession to co-operate.

Our view is that no one needs to persuade, entice, or coerce the medical profession into looking after patients. That it is not therefore necessary for the medical profession to be participants in such a plan. That the patient should have free choice of doctor. That the patient should have his responsibility to that doctor, and that the patient should insure himself separately from that relationship.

COMMISSIONER FIRESTONE: Well, when we had the Association before us we were discussing two aspects of that compulsory feature. One was compulsory belonging to the plan of the insured, and secondly, compulsory belonging of the physicians, or co-operation by physicians under the plan, and the supplementary remark which you made applied to the second part of the compulsion.

My question related to the first part of the compulsion, which it was suggested to us that the plan should cover all the people of the Province of Quebec. How do you feel about that part of the compulsory proposal of coverage?

DR. GOLDBLOOM: Sir, I don't believe that these two aspects are separable. If there is compulsion, then there is compulsion on both sides, because compulsion can only come from government. It has to be legislative. Once it is legislative, the government has assumed an obligation to see that people receive their medical care, therefore, compulsion must be imposed on the medical profession.

Our view in this is one made on principle, on science and medical profession rather than other patients. That is to say therefore necessary for the medical profession to be partitioners in such a place. That the patient should have free choice of doctor. That the patient should have his responsibility to that doctor, and that the patient should insure himself separately from that relationship.

CONTRIBUTOR FINNEY: Yes, when we [illegible] of that compulsory feature. It was compulsory belonging to the plan of the insured, and secondly, compulsory bringing of the pay roll, or co-operation by physicians under the plan, and the supplementary remark which you made applies to the second part of the compulsion.

My question related to the first part of the compulsion, which it was suggested to us that the plan should cover all the people of the country of Canada. How do you feel about that part of the compulsory feature of coverage?

Dr. [illegible]: Sir, I don't believe that these two aspects are separable. If there is compulsion, then there is compulsion on both sides. Compulsion can only come from government. It has to be legislative. Once it is legislative, the government has assumed an obligation to see that people receive health medical care. Therefore, regulations must be imposed on the medical profession.

COMMISSIONER FIRESTONE: If I may recall what we were told in Quebec City, it was suggested to us that the Association would prefer, and they were hopeful that the physicians would co-operate under such a plan, on a voluntary basis.

Could you not visualize that, as you said yourself, nobody needs to force doctors. They are going to look after patients, so why would there need to be compulsion once such a plan is in operation, particularly the physicians involved in developing the plan, why is there compulsion needed on the part of the doctors?

DR. GOLDBLOOM: Compulsion is an exclusive thing. It implies a monopoly, because it eliminates competition and in this country we have an attitude against monopoly and we have a Combines Act to enforce it.

We subscribe to this situation, and feel there should be a competitive situation in the insurance field, so that freedom can be maintained. The system under which we live is a system which involves checks and balances, and these checks and balances involve a certain competition between government when it enters private life and private enterprise, and if compulsion is imposed, private enterprise is eliminated.

In the words of Lord Acton in 1924:

"Power tends to corrupt, and absolute power corrupts absolutely"

COMMISSIONER FIRESTONE: But we have made a little progress since 1924.

COMMISSIONER McCUTCHEON: We haven't

recall that we were told in Quebec City, it was suggested to us that the Association would prefer, and they were hopeful that the physicians would co-operate under such a plan, on a voluntary basis.

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COMMISSIONER FRANCHOVY: But we have made a little progress since 1948.

CHAIRMAN DOCTOR HUGGS: We haven't

made that much progress in philosophy.

THE CHAIRMAN: They have made that kind of progress too in Russia since 1924.

COMMISSIONER FIRESTONE: If I may come back to Quebec. We have had these proposals from this Association in Quebec City, and it is a proposal for a compulsory plan, compulsory as far as coverage of the insured population of the Province of Quebec is concerned. Does your Association support such a plan, or do you feel that you would not support such a plan?

DR. GOLDBLOOM: We would not support such a plan, and we have proposed an alternative.

COMMISSIONER FIRESTONE: Yes, I understand that. It was explained to us that the Association did expect that such a plan will be supported by the medical profession, but you have made it clear that you would not. Thank you very much.

If I may follow up one point that was raised a little earlier by our Chairman, in connection with the method of reimbursement, and you may recall that on page 17, in the third paragraph, at the bottom of the paragraph you say:

> "We favour therefore a reimbursement or indemnity role for the insurer outside that relationship.",

and you dealt with some of the implications of this particular suggestion in answer to questions of the Chairman, and may I just give you my understanding of what you said, and please correct me again if I didn't quite get the point that you were putting to us.

is this work performed legally today.

THE CHAIRMAN: They have never had

kind of pressure too in Russia since 1924.

COMMISSIONER LEGGOTT: If I may come

back to Quebec. We have had these proposals from the Association in Quebec City, and it is a compulsory plan, compulsory as far as any case of the insured population of the province of Quebec is concerned. Does your Association support such a plan, or do you feel that you would not support such a plan?

DR. CHAMBERS: We would not support such a plan, and we have proposed an alternative.

COMMISSIONER MACGUIGAN: Yes, I understand that. It was explained to us that the association did support that such a plan will be supported by the medical profession, but you have made it clear that you would not. Thank you very much.

If I may follow up one point that you raised a little earlier by our Chairman, in connection with the method of reimbursement, are you very well that on page 17, in the third paragraph, at the bottom of the page you say:

"We favor therefore a reimbursement or indemnity role for the insurer outside

are you dealt with some of the implications of this very helpful suggestion in answer to questions of the Chairman. And may I just give you an opportunity of what you said, and please correct me again if I make quite sure the point that you are making to us.

As I understood, sir, that persons who pay premiums to this fund, when they see the doctor they will be looked after in the regular manner, will receive a bill from the doctor, pay the doctor and then, they in turn present the bill to the insurance company or commission or agency, and they in turn are reimbursed.

DR. GOLDBLOOM: The receipts.

COMMISSIONER FIRESTONE: Yes. Then you went further, and said as far as the medically indigent are concerned, you would visualize a system whereby these people, their premium would be paid by government, by the State, and they would be issued a card which they would present to the physician, and the physician then would look after them in the same manner as the other patients, but at the end of the month, submit an account to the commission, and then collect all the payments due to him for services rendered.

Was my understanding correct?

DR. GOLDBLOOM: Yes, that is correct, sir.

COMMISSIONER FIRESTONE: Well now, sir, I take it that the doctor in the case of the indigent and the medically indigent patient would be collecting the fee from the fund, but he would be providing the same medical care service as the patient who paid him directly?

DR. GOLDBLOOM: Yes, sir.

COMMISSIONER FIRESTONE: So there would be no difference in the quality of service?

DR. GOLDBLOOM: This is a matter of principle, sir.

As I understand, sir, that premiums are may premiums to pay for, when they get the money they will be looked after in the regular manner, will receive a bill from the doctor, pay the doctor and then, they in turn present the bill to the insurance company or association or agency, and they in turn are reimbursed.

COMMISSIONER FLEMING: Yes. Then you want instead, and said so far as the medically indigent are concerned, you would eliminate a system whereby those people, their premium would be paid by government, by the State, and they would be issued a card which they would present to the physician, and the physician then would look after them in the same manner as the other patients, but at the end of the month, submit an account to the commissioner, and then collect all the expenses due to him for services rendered.

Was my understanding correct?

DR. MCBLOOM: Yes, that is correct.

COMMISSIONER FLEMING: Well now, sir, I were it that the doctor in the case of the indigent and the medically indigent premium would be collecting the fee from the State, but he would be providing the same medical care service as the patient who paid him directly.

DR. MCBLOOM: Yes, sir.

COMMISSIONER FLEMING: So there would be no difference in the quality of service.

DR. MCBLOOM: This is a matter of

COMMISSIONER FIRESTONE: Yes, it is a very sound principle, and the medical profession is to be congratulated for not making any discrimination. It is a fact that the fund is paying the doctor bills for the indigent and the medically indigent. Is this fact in any way affecting the relationship between patient and doctor?

DR. GOLDBLOOM: It should not, sir.

COMMISSIONER FIRESTONE: And therefore, in fact, it does not?

DR. GOLDBLOOM: It does not, no, sir.

COMMISSIONER FIRESTONE: Therefore, would you not say that the method of payment should not, or does not affect the patient/doctor relationship?

DR. GOLDBLOOM: There are two aspects to the method of payment. One is the technicality of how payment is transmitted from one party to the other. The other, the sense of obligation involved.

Here we are dealing with a special category of the population, a category that will always I am sure be with us, but a category that we would rather not have with us, and this is why we say in our brief the government should devote every effort towards raising the standard of living.

COMMISSIONER FIRESTONE: Well, again, this is a very laudable objective, and I am sure it is endorsed by everybody here on this side and the other side, but to come back to the question that I have put before you. I understand that as far as patient/doctor relationship is concerned, or the quality of the service is

COMMISSIONER FINSTOWE: Yes, it is a very sound principle, and the medical profession is to be congratulated for not making any discrimination. It is a fact that the fund is paying the doctor bill for the indigent and the medically indigent. Is this -- that in any way affecting the relationship between patient and doctor?

DR. GOLDBLOOM: It should not, sir.

In fact, it does not?

DR. GOLDBLOOM: It does not, no, sir.

Would you not say that the method of payment should not or does not affect the patient/doctor relationship?

DR. GOLDBLOOM: There are two aspects to the method of payment. One is the feasibility of how payment is transmitted from one party to the owner. The other, the sense of obligation involved.

Here we are dealing with a special category of the population, a category that will always I am sure be with us, but a category that we would rather not have with us, and this is why we say in our brief the government should devote every effort towards reducing the abundance of indigent.

This is a very laudable objective, and I am sure it is endorsed by everybody here on this side and the other side, but to come back to the question that I have put before you. I understand that as far as patient/doctor relationship is concerned, or the quality of the service

concerned, there is no difference whether this payment is made directly by the patient to the doctor, or in the other case, by the State or the fund to the doctor, is that correct?

DR. GOLDBLOOM: It is correct if we recognize that this is a special category. It would not apply to the entire population, if the entire arrangement were on this basis.

COMMISSIONER FIRESTONE: I would like you to explain to me why a man that earns $4,000.00, his relationship with the doctor may be affected, while the man who earns $3,000.00, his relationship would not be affected when the payment is made by a fund. Why should the man of $4,000.00, who would not be, say, in the medically indigent group, why should his relationship be affected if the fund should pay for him, while the man making $3,000.00 would not be affected? Why?

DR. GOLDBLOOM: We would feel, sir, that this sense of responsibility and mutual obligation applies to all doctor, patient relationships and that it would apply equally to the relationships of the physician with those patients who are not in a position to pay, but that the doctor as a citizen and human being takes special consideration in regard to these patients. You must realize, sir, as has been brought out before, that the doctor is pychologically in a disadvantageous situation because he makes his living out of suffering of others, and in a sense, it may be, sir, that the help that the doctor can give to those who are in need

[illegible]

ie made directly in the past on us the doctor, or in the other case, by the fees or the fund to the counsel, in

Dr. [illegible]: It is clear, if we recognize that this is a social category. It would not apply to the entire overall [illegible], if the doctor practices work on this basis.

CHAIRMAN [illegible]: I would like you to explain to me why a man that earns $[illegible], his relationship with the doctor may be altered, while the man who earns $[illegible] his relationship would not be affected when one payment is made by a fund. Why should the man of $[illegible], who would not be, say, in the medically indigent group, not enjoy his relationship as efficacious if the fund pay for him, while the man making $[illegible] would not be satisfactory. Why?

Mr. [illegible]: He would feel, sir, that this sense of responsibility and mutual obligation applies to all doctors, particularly relationships and that it would apply equally to the relationships of the physician with those patients who are in a position to pay. But that the doctor is obliged to do common being taken special consideration is regard to these patients.

[illegible] sir, we do not need brought out before, that the doctor is obviously in a disadvantageous position because he loses his income out of proportion to the time spent. It may be, say, that the doctor that [illegible] to take care in many

can justify to himself the way in which he makes his living.

COMMISSIONER BALTZAN: If I may interject at the moment you seem to imply actually what will change under the circumstances that are being discussed now, the human factor, the attitude on the part of the patients, the attitude on the part of physicians under these terms which is a matter of attitude which indirectly, not directly, if I adduce that correctly could affect the quality, but it doesn't imply because of a change that the quality is directly and definitely going to be affected to begin with, and I repeat it is very likely that the attitude on the part of one and the attitude on the part of the other not being what the usual attitude that would be expected is, that could change and indirectly perhaps interfere or reflect on quality?

DR. GOLDBLOOM: Well, sir, I would like to say -- there are two things I would like to bring into this discussion. The first is that there is a certain subtlety that goes beyond the direct relationship between the physician and patient. If the physician is to receive the major part or all of his remuneration from a third party then a situation of potential conflict of interest arises. We were asked earlier about our attitude towards doctor sponsored plans. We expressed the attitude which wasn't in favour of the expansion of doctor sponsored plans because of the views that we have expressed. We feel where a third party pays that a conflict of interest frequently --

can justify to himself the way in which he makes his

COMMISSIONER BATTAWN: If I may intervene at the moment you seem to imply actually what will change under the circumstances that are being discussed now, the human factor, the attitude on the part of the patients, the attitude on the part of physicians under these terms which is a matter of attitude which influences, not necessarily, if I choose that correctly could affect the quality, but it doesn't imply because of a change that the quality is directly and definitely going to be affected to begin with, and I repeat it is very likely that the attitude on the part of one and the attitude on the part of the other not being what the usual attitude that would be expected is, that could change and incidentally perhaps interfere or influence quality.

Dr. GOLDBERGER: Well, sir, I would like to say -- there are two things I would like to bring into this discussion. The first is that there is a certain authority that goes beyond the direct relationship between the physician and patient. If the physician is to receive the major part or all of his remuneration from a third party, then a situation of potential conflict of interest arises. We were asked earlier about our attitude towards insurance plans. We expressed the attitude which was in favor of the expansion of insurance sponsored plans because of the values that we have enumerated. We then where a third party pays there is a condition of interest. Therefore --

I won't say frequently, I withdraw that word -- may arise that is not in the best interests of the patient. Hospitalization in situations that whether a patient is hospitalized or not is governed by considerations other than immediate medical matters, governed by the questions of who pays and who pays how much. We have various restrictions imposed on the profession of the kind of care that we would like to provide through budgetary restrictions because a third party is paying.

Now, the doctor recognizes an indigent and takes this into consideration and acts accordingly. If the person is in the intermediate category, the gray area which has been discussed, the doctor under our plan is at liberty to reduce his charges and take into consideration the situation in which that person or family finds themselves.

The other thing I would like to call to your attention, sir, is that the indigents are not the only categories of the population who are looked after by the doctor without charge. The other group is the doctor and his family, and I would like to tell you, sir, although perhaps you know it already, that in the majority of instances, the doctor will beg another doctor to forget the principle of professional courtesy and submit a bill because he will feel more comfortable in the relationship.

COMMISSIONER FIRESTONE: Are most practicing physicians in the Province of Quebec participating members in the Blue Cross?

DR. GOLDBLOOM: No, sir, I don't

I won't say "remarkably", I will even that word -- may
argue that it not in the best interests of the patient,
hospitalization. In situations like, whether a patient is
hospitalized or not is governed by considerations other
than immediate medical matters, governed by the questions
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and submit a bill because he will feel more comfortable
in the relationship.

COMMISSIONER FRENCHEWS: Are most
practicing physicians in the Province of Quebec partici-
pating members in the Blue Cross?

DR. SOLOMOWICH: No, sir, I don't

1 believe that the majority are.

2 COMMISSIONER FIRESTONE: A large

3 number of participating doctors in Blue Cross?

4 DR. GOLDBLOOM: Yes, a large number

5 are.

6 COMMISSIONER FIRESTONE: How does the

7 doctor collect from the Blue Cross?

8 DR. GOLDBLOOM: The participating

9 physician?

10 COMMISSIONER FIRESTONE: The partici-

11 pating physician.

12 DR. GOLDBLOOM: As soon as all the

13 forms are received he receives the cheque from the Blue

14 Cross. This is an indemnity plan which sends back a

15 form stating that the Blue Cross has paid so much and

16 the patient is obligated to pay the balance.

17 COMMISSIONER FIRESTONE: Does the fact

18 that the Blue Cross pays the doctor's fee directly to

19 the doctor affect the patient, doctor relationship?

20 DR. GOLDBLOOM: It may provide a

21 conflict of interest in the same sense I suggested to

22 you before.

23 COMMISSIONER FIRESTONE: Have you had

24 complaints from either patients or doctors about this

25 system that is presently in operation in the Blue Cross?

26 DR. GOLDBLOOM: I don't think I am

27 qualified to answer that. Such complaints wouldn't

28 necessarily come to our Association.

29 COMMISSIONER FIRESTONE: I take it

30 from the fact the system continues in existence and a

believe that the majority are.

number of participating doctors [illegible]

COMMISSIONER WEBSTER: How does the

DR. JOHNSON: As soon as all the forms are received he receives the cheque from the Blue Cross. This is an independent plan which works back a form stating that the Blue Cross has paid so much and the patient is obligated to pay the balance.

COMMISSIONER WEBSTER: Does the fact that the Blue Cross says the doctor, the directly to the doctor relieves the patient, insofar relationship

LT. JOHNSON: It may provide a conflict of interest in the same manner as mentioned to you before.

COMMISSIONER WEBSTER: Have you had complaints from either subscribe or doctors about this system that is presently in operation in the Blue Cross?

DR. COLDBOOM: I don't think I am qualified to answer that. Such complaints would necessarily come to our Association.

From the fact that section contracts in existence and a

large number of doctors continue to participate, it must be fairly acceptable both to doctors and patients.

DR. GOLDBLOOM: Some considerations of it are acceptable, sir, but we are not satisfied to remain with the system that we have, and this is why we have proposed the plan which you have before you.

COMMISSIONER FIRESTONE: Have you had any complaints from patients that as a result of this system that has been in operation in the Province of Quebec of the quality of medical care service? Yourselves as a professional association might hear about complaints of quality due to this one fact. Have you had any complaints of that type?

DR. GOLDBLOOM: I am not aware of such complaints about the quality of the professional care where we refer to the value and integrity of the service which the physician provides to the patient.

COMMISSIONER FIRESTONE: In other words, we have in operation in the Province of Quebec a system whereby the doctors are paid directly by the insuring agency and there appears to be very little complaint against the system and as far as you know yourself, very little complaint as to the effect on quality.

Would you suggest that experience suggest such a system is valuable and workable and perhaps more efficient than a system whereby people have to collect from the insuring agency individual fees and then pay them out to the doctor?

DR. GOLDBLOOM: I will call to your attention, sir, this is an indemnity plan and it issues

large number of courses conducted in hospitals. It must be fairly cooperative, both as teachers and students.

DR. COLDSTREAM: Some commissioners of it are acceptable, but we are not satisfied to remain with the system that we have, and this is why we have proposed the plan which you have before you.

COMMISSIONER FRASER: Have you had any complaints from patients that as a result of this system that has been in operation in the Province of Ontario of this quality of medical care service? Yourselves as a professional association might have some complaints of quality due to this one fact. Have you had any complaints of that type?

DR. COLDSTREAM: I am not aware of such complaints about the quality of the practice, and here where we refer to the value and intensity of the service which the physician provides to the patient.

COMMISSIONER FRASER: In other words, we have in operation in the Province of Ontario a system whereby the services are paid directly by the insuring agency and there appears to be very little complaint against this system and as far as you know personally, very little complaint as to the effect on quality.

Would you suggest that experience towards such a system is valuable and we hope and believe more efficient than a system whereby people have to collect from the insurance agency individual fees and then pay them out to the doctors?

DR. COLDSTREAM: Well sure, to your association, sir, this is an insurance plan and it leaves

a statement to the patient of what his obligation is to the physician and states we have paid a certain proportion and you are obligated for the balance, and the physician uses his discretion about the balance according to the means of the family he is dealing with. I would also like, if I may, to correct what you have just said, the order in which you stated the action is the reverse, that under the plan which we propose, the patient would pay to the doctor and would present the doctor's receipted bill to the insurer.

COMMISSIONER FIRESTONE: Why wouldn't you feel a system whereby he would collect directly from the insurer wouldn't be a more efficient system? Are you against it from the matter of principle of doctor, patient relationship, or because you think it is a more efficient system, or both counts?

DR. GOLDBLOOM: On the basis of doctor, patient relationship, sir, and on the basis of where the doctor's obligation lies. The doctor's obligation lies to the patient and not to the insurance plan.

COMMISSIONER FIRESTONE: But you would have no objection if the patients and the insurance agency work out a plan that is satisfactory to both of them, and the patient wanted to have the payment made directly to the doctor, would the doctor have any objections if that is what the patient wants?

DR. GOLDBLOOM: We are citizens of a democracy and if this is the result of a democratic process, then we would co-operate with it.

COMMISSIONER FIRESTONE: In other words,

the physician and whether we have paid a certain proportion and you are obligated for the balance, and the physician uses his discretion about the balance according to the means of the family he is dealing with. I would also like, if I may, to correct what you have just said, the order in which you started the question is the reverse, that under the plan which we propose, the patient would pay or the doctor and would present the doctor's receipted bill to the insurer.

COMMISSIONER PIERCEWICZ: Why wouldn't you feel a system whereby we would collect directly from the insurer wouldn't be a more efficient system? Are you against it from the manner of principle of doctor, patient relationship, or because you think it is a more efficient system, or both counts?

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COMMISSIONER PIERCEWICZ: But you would have no objection if the patients and the insurance agency work out a plan that is satisfactory to both of them, and the patient wanted to have the payment made directly to the doctor, would the doctor have any objections if that is what the patient wants?

DR. GOLDSBROOM: We are entirely for a democracy and if this is the result of a democratic process, then we would acquiesce with it.

COMMISSIONER PIERCEWICZ: In other words,

you would co-operate in a plan which would provide for comprehensive coverage on a full basis with payments made directly by the insuring agency to the doctors?

DR. GOLDBLOOM: Professor Firestone, the medical profession would co-operate with any plan which in the wisdom of the government of the province is correct.

COMMISSIONER FIRESTONE: That is a very enlighting statement. Thank you.

COMMISSIONER STRACHAN: If I may be permitted two or three questions, Mr. Chairman.

You have made considerable reference to paramedical personnel and to some degree you have detailed them, but to me, over lunch this term paramedical has become very nebulous. Would you care to detail exactly what you mean by paramedical personnel as related to your brief?

DR. GOLDBLOOM: In this case we have, we referred directly to those people who assist the doctor, nurses -----

COMMISSIONER STRACHAN: You mean physicians?

DR. GOLDBLOOM: Physicians, excuse me, and I have carefully removed every reference to doctor in the brief in favour of the word physician. Excuse me for that slip.

COMMISSIONER STRACHAN: I wanted to get it clear.

DR. GOLDBLOOM: I heard you in Vancouver, sir.

you would co-operate in a plan which would provide for comprehensive coverage on a full basis with payments made directly by the insuring agency to the insured?

the medical profession would co-operate with any plan which in the wisdom of the government of the province is correct.

COMMISSIONER FURLONG: That is a very enlighting statement. Thank you.

COMMISSIONER SYMACHAN: If I may be permitted two or three questions, Mr. Chairman

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COMMISSIONER SYMACHAN: I wanted to get it clear.

DR. GOLDFLOOM: I meant man in Vancouver,

THE CHAIRMAN: I would like to know the difference myself.

DR. GOLDBLOOM: Those personnel who assist the physician, that is to say nurses, occupational therapists, physiotherapists, social workers and so on.

COMMISSIONER STRACHAN: What is so on. I have all those.

DR. GOLDBLOOM: All the various technicians and so on. We have no intention of speaking for the dental profession in this brief. The dental profession has presented its own point of view. Neither the inclusion or exclusion as far as our principle is concerned. We feel the plan we have proposed, being a reimbursement plan, would be every bit as applicable to dental care or drug care. It would have to be budgeted for.

COMMISSIONER STRACHAN: Are you thinking of psychologists?

DR. GOLDBLOOM: Yes, sir.

COMMISSIONER STRACHAN: As paramedical?

DR. GOLDBLOOM: Yes, sir.

DR. STRACHAN: That is the area I was thinking about. It wasn't particularly dental I had reference to.

One other question I would like to put to your division: Do you confirm the resolution of the Canadian Medical Association regarding fluoridation?

DR. GOLDBLOOM: Yes, sir, we do indeed.

COMMISSIONER STRACHAN: Thank you, Mr. Chairman.

THE CHAIRMAN: I would like to know [illegible]

DR. CONNELLY: Since personnel who assist the physician, that is to say nurses, orderlies [illegible]

I have all those.

DR. [illegible]: All the [illegible] technicians and so on. We have no intention of speaking for the dental profession in this brief. The dental profession has presented its own point of view. Neither the inclusion or exclusion as far as our principle is concerned. We feel this plan we have proposed, being a reimbursement plan, would be every bit as applicable to dental care or drug care. It would have to be broadened for.

COMMISSIONER STRACHAN: Are you thinking of psychologists?

COMMISSIONER STRACHAN: As paramedicals?

DR. [illegible]: Yes, sir.

DR. SPRYSZAK: That is the area I was thinking about. To mention particularly dental I was referring to.

One other question I would like to put to your division: To what extent the association of the [illegible]

DR. [illegible]: Yes, sir, we do indeed.

COMMISSIONER STRACHAN: Thank you, Dr.

COMMISSIONER BALTZAN: I started and didn't finish it before we left, in connection with privileges in hospitals, have you enough hospital beds and accommodations to admit to your staff, say, one who is fully specialized and ready to assume his specialty? Does he automatically come on to any one of your staffs?

DR. GOLDBLOOM: No, sir, the fact of graduation from medical school does not automatically carry with it ----

COMMISSIONER BALTZAN: Beyond medical school.

THE CHAIRMAN: Specialty.

DR. GOLDBLOOM: In any specialty, sir, the physician can apply to a hospital and be passed by its credential committee. All appointments are annual appointments and have to be merited each year by every physician.

COMMISSIONER BALTZAN: And it isn't always possible for even a specialist to have an opportunity to become a member of the staff just because he is a specialist as against the man in general practice?

DR. GOLDBLOOM: That is correct, sir.

COMMISSIONER BALTZAN: That is what I wanted to hear from you. Thank you.

THE CHAIRMAN: On that point, you say merited. Assuming there is nothing wrong with this fellow, a specialist that is qualified and is morally acceptable. He has received a certificate under the Quebec law entitling him to practice his specialty and there is nothing wrong, no impediment on the moral side.

COMMISSIONER BAILLIE: I started to finish it before we left, in connection with provisions in hospitals, have you enough hospital beds and accommodation to admit to your staff, say, one who is fully specialized and ready to assume his specialty, does he automatically come on to any one of your staffs.

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COMMISSIONER BAILLIE: That is what I wanted to hear from you. Thank you.

THE CHAIRMAN: On that point, you say restricted. Assuming there is nothing wrong with this fellow, a specialist that is qualified and is morally acceptable. He has received a certificate under the Canada law entitling him to practise his specialty and there is nothing wrong, no impediment on the moral side.

Do you say that person does not necessarily, cannot necessarily be admitted to a hospital to practice?

DR. GOLDBLOOM: Not by virtue of holding the certificate. He has to apply.

THE CHAIRMAN: I know he has to apply. If he applies and has the requirements, can you just reject him merely because you don't want him?

DR. GOLDBLOOM: The hospital as an independent institution has that liberty, sir.

THE CHAIRMAN: Do you support that?

DR. GOLDBLOOM: It is a very complex problem, sir. The hospital has a certain staff and it has a certain patient load.

THE CHAIRMAN: The hospital generally acts on the advice of its medical staff in those matters?

DR. GOLDBLOOM: The hospital might feel it was over-staffed in certain departments or adequately staffed in certain departments and they couldn't possibly take on an additional physician and provide him with the beds for his patients and the patient time and the operating room time that he would require.

THE CHAIRMAN: You say this does happen in Montreal in 1962?

DR. GOLDBLOOM: It does happen.

THE CHAIRMAN: You also say there is a shortage of personnel, of doctors, physicians in Montreal.

DR. GOLDBLOOM: Yes, there is a relative shortage.

THE CHAIRMAN: What is the degree of relativity?

THE CHAIRMAN: I know he has to apply.

DR. GOLDBLOOM: The hospital as an independent institution has that liberty, sir.

THE CHAIRMAN: Do you support that?

DR. GOLDBLOOM: It is a very complex problem, sir. The hospital has a certain staff and it has a certain patient load.

THE CHAIRMAN: The hospital generally acts on the advice of its medical staff in those matters.

DR. GOLDBLOOM: The hospital might find it was over-staffed in certain departments or inadequately staffed in certain departments and they couldn't possibly take on an additional physician and provide him with the beds for his patients and the present time and the operating room time that he would require.

THE CHAIRMAN: You say this does happen.

DR. GOLDBLOOM: It does happen.

THE CHAIRMAN: You also say there is a shortage of personnel, of doctors, physicians in Montreal.

DR. GOLDBLOOM: Yes, there is a relative shortage.

THE CHAIRMAN: What is the cause of

DR. GOLDBLOOM: We haven't been able to find a figure we would consider reliable to know what would be the ideal proportion should be. Each specialty as well as total figures which have been collected -- the relationship of number of physicans to number of population, each specialty has a figure of how many specialists there should be to population.

THE CHAIRMAN: You see, doctor, this comes to us as a very real situation. If we hear from one part of the country to the other of shortages and they are not suggested as marginal shortages, they are suggested as shortages in almost catastrophic figures when forecast to 1980, and then you say, A, general practitioners can't find hospitals in which to practice and specialists qualified and entitled to practice, can't find hospitals in which to practice. How does this thing add up?

DR. GOLDBLOOM: No, sir, not that specialists or even general physicians can't find hospitals in which to practice, but that there are certain hospitals which have a full complement of staff and don't have room for others. There are other hospitals and there are other areas where these doctors are needed and where they could certainly find great use for their talents.

THE CHAIRMAN: Areas, you mean out in the Seven Island District?

DR. GOLDBLOOM: Not necessarily, sir, not at all.

THE CHAIRMAN: Let's get a little

DR. GLENDON: We haven't been able to find a figure we would consider reliable or even one would be the ideal proportion simply for each specialty as well as total figures which have been collected - the relationship of number of practitioners to number of population, each specialty has a figure of how many

THE CHAIRMAN: You say, gentlemen, that comes to us as a very real situation. If we hear from one part of the country to the other of shortages and they are not suggested as marginal shortages, they are suggested as shortages in almost overwhelming figures when forecast to 1980, and then you say, A. General practitioners can't find hospitals in which to practice and specialists qualified and entitled to practice, can't find hospitals in which to practice. How does this thing add up?

DR. GLENDON: No, sir, not the specialists or even general physicians can't find hospitals in which to practice, but that there are certain hospitals which have a full complement of staff and don't have room for others. There are other hospitals and there are other areas where these doctors are needed and where they could reasonably find great use for their talents.

THE CHAIRMAN: Areas, you mean out in the Seven Islands Districts.

DR. GLENDON: Not necessarily in city, too as well.

THE CHAIRMAN: Let's get a little

closer, but outside of Montreal?

DR. GOLDBLOOM: Even within Montreal there are suburban areas of the city where there is difficulty in establishing enough specialties. There are in the centre of the city teaching hospitals affiliated with the Universities that are considered very desirable hospitals. They can't possibly take all the applicants that come to them. It would be chaos if they did. There are other hospitals that could use their services very well indeed.

In the process of his training a man going into a specialty takes care to investigate where he will be acceptable on staff. As he goes on through his training in the hospital in any such establishment, if it is a teaching hospital with university affiliation it will guide that physician and get him to an area where his services can be used.

THE CHAIRMAN: Where is the breakdown? With all this care, planning, guidance, your specialist has no hospital to go to.

DR. GOLDBLOOM: He has a hospital to go to. He may not be able to, if he hasn't arranged for it in advance through his training, having his training under the aegis of a particular university or particular hospital, he cannot go out of the blue and get an appointment in a hospital of outstanding reputation where any doctor would be pleased to be on the staff. He may have to find another hospital at which he can practice. There is need and there is room.

THE CHAIRMAN: Fine, doctor. I want

closer, but outside of Tennessee?

There are southern areas of the city where there is difficulty in establishing enough specialties. Where are in the centre of the city teaching hospitals affiliated with the Universities that are considered very desirable hospitals. They can't possibly take all the applicants that come to them. It would be absurd if they did. There are other considerations that could use their services very well indeed.

In the process of his training a man going into a specialty seems to increasingly see he will be acceptable on staff. As he goes on through his training in the hospital in any such specialtiness, if it is a teaching hospital with conveniences, institutions will guide that physician one way or another to an area where his services can be used.

THE CHAIRMAN: Where is the specialty? With all this care, observing, guidance, your specialist has no hospital to go to.

DR. GOODCHILD: He has a hospital to go to. He may not be able to, it may have arranged for it in advance through his training, having his training under the auspices of a particular university or particular hospital. He cannot go out of the blue and get an appointment in a hospital of outstanding reputation where any doctor would be pleased to - on his merit. He may have to find another hospital at which he can practice. There is never and there is room.

MR. CHAIRMAN: Here, doctor, I and

to thank you very sincerely for your presentation, for your submission and for the very fine way in which you have dealt with the questions that have been put to you. I must say you have been very, very helpful. We thank you very much.

DR. GOLDBLOOM: Thank you, gentlemen.

DR. DuBERGER: If you would allow me, I would like to speak in French in conclusion. I would like to thank you, Mr. Chairman, and your colleagues and Madamoiselle Girard for the courtesy and interesting way in which this discussion was carried on. We thank you for your courtesy once again, sir, thank you.

COMMISSIONER GIRARD: I whispered to the Chairman that we have the same thing to say with respect to you. He said I should say it myself. I should therefore like to thank the members of the delegation for your kind words with respect to myself at the beginning of the session. Thank you very much, gentlemen.

THE CHAIRMAN: We now have the Association des Medecins de Langue Francaise du Canada, Filiale du Quebec. This will be exhibit number 236.

--- EXHIBIT NO. 236 Submission of Association des Medecins de Langue Francaise du Canada.

so thank you very kindly for your presentation, Mr.

I must say you have left us, very happily. We enjoy you very much.

DR. COLLIN: Thank you, Gentlemen.

DR. HAMMOND: If you would allow me, I would like to speak to Dr. Collin. I would like to thank you, Dr. Chairman, and Your Excellency and Madame Lalle Grand for the courtesy and hospitality in which this discussion was carried out. We thank you for your courtesy once again, sir, thank you.

CONSTITUTION READ: I announce to the Chairman that we have the same task. So may with respect to you. He said I about -- in speech. I therefore like to thank the members of the secretariat for your kind words with respect to myself on the occasion of the session. Thank you very much, Gentlemen.

THE CHAIRMAN: We now have the Association des Medecins de langue Française du Canada Filiale du Quebec. This will be exhibit number 246.

--- EXHIBIT NO. 246 Association of Francophone Medicine de langue Française du Canada.

SUBMISSION OF

ASSOCIATION DES MEDECINS DE LANGUE FRANCAISE DU CANADA

Appearances:

Roland Decarie

Marc Geoffroi

Roland Blais

Jacques Leger

Andre Leduc

Raymond Caron

Pierre Smith

Edouard Desjardins

THE CHAIRMAN: Dr. Leger.

DR. LEGER: Mr. Chairman, ladies and gentlemen, it is a great pleasure that I as president of the Quebec Section of L'Association des Medecins de Langue Francaise du Canada, Filiale du Quebec, introduce my colleagues. At my extreme left is Dr. Edouard Desjardins, a member of the executive; Dr. Pierre Smith, who is director of the Public Relations Department; Dr. Raymond Caron, who is deputy-secretary; Dr. Andre Leduc, who is deputy to the general director of the Association. At my extreme right, Dr. Roland Decarie, a former president of our Section; Dr. Marc Geoffroi, who is our secretary, and Dr. Roland Blais who is secretary-general of the National Association.

Gentlemen, on the 20th of June, 1961, His Excellency, the Governor General approved the establishment of the Royal Commission of Inquiry into Health

Roland Tessier

Pierre Geoffroy

Helene Pilon

Jacques Lesage

André Lyonc

Pierre Amiot

Edouard Desjardins

Mr. Allen: ... Mr. Chairman, Fellow-Members, gentlemen, it is a great pleasure that I as President of the Queen Elizabeth of Bilingualism Commission of Canada, with a [illegible] colleagues. At my extreme left is Mr. Edouard Desjardins, a member of the executive; Mr. Pierre Amiot, who is director of the Public relations department; Mr. Raymond Lesage, who is deputy-secretary; Mr. André Lyonc, who is deputy to the general director of the Commission. At my extreme right, Mr. Roland Tessier, a member of our Secretariat; Mr. Marc [illegible], who is our secretary, and Mr. Edouard Pinsonneault, who is secretary-general of the Commission.

Gentlemen, on the 14th of June, Her Excellency, the Governor General approved the establishment of the Royal Commission. It recently been decided

Services in Canada. The Hall Commission was charged with the task of making the survey and reporting on the present needs and future needs with respect to health services of the population of the country, as well as on the resources needed to ensure such services, and to recommend measures compatible with the disposition of legislative power in Canada, which in the opinion of the Commissioners would ensure the best possible medical care for all Canadians.

In the accomplishment of this gigantic task it was agreed to furnish all Canadians regardless of their social or professional positions and to all organizations and to all institutions and to all associations the opportunity of voicing their opinions. The purpose of this inquiry concerned the personal life of all Canadians, educational, social, economic life, as well as constitutional aspects. It deeply concerns the medical profession, and it would be extremely unfortunate for this study if Canadian physicians through the intermediary of their organizations and professional associations didn't show keen interest and take active part in discussion of problems so close to them.

The Canadian physician is aware of the needs of the Canadian public with respect to health. It is his duty to make known his views as the profession has not the sole role of giving medical care, but to also participate in the administration of society. Unless it plays this role with respect to public health, governments will eventually bear responsiblity for all medical services.

This is the spirit which animates the

compatible with the disposition of legislative power in Canada, which in the opinion of the Commissioners would ensure the best possible medical care for all Canadians.

In the accomplishment of this gigantic task it was agreed by French all Canadians regardless of their social or professional positions and to all organizations and to all institutions and to all associations the opportunity of voicing their opinions. The purpose of this inquiry concerned the personal life of all Canadians, educational, social, economic life, as well as constitutional aspects. It deeply concerns the

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The Canadian physician is aware of the needs of the Canadian public with respect to health. It is his duty to make known his views as the professation are not the sole role of giving medical care, but to also participate in the administration of medicine. Unless it plays this role with respect to public health, Governments will eventually bear responsibility for all medical services.

This is the method which enhances the

work done by our section of L'Association des Medecins de Langue Francaise du Canada, Filiale du Quebec. Our organization was founded in order to support the professional interests of its members which amount to some four thousand concentrated throughout the regions and territories of the province. Our association is interested in the major problem of public health in this province. We have studied this problem in all aspects, professional, social, scientific and legal aspects and we have never feared to take a position when the interests of public health were involved. The association, therefore, is devoted to the cause of public health, and the medical profession, wherever our competence and our experience is required, we are at the disposal of the governments, of hospital services, and of national and provincial societies dealing with public health, particularly when a task which calls for our knowledge, concerns our responsibilities and inspires ourselves on the basis of the Order-of-Council of 1961, 883, which was passed by the Canadian Government the 20th of June, 1961.

We hope to furnish valid contributions to the inquiry presently being conducted. Our main objective is to deal with the services of health for the population of the Province of Quebec.

The development in our society has resulted in an impressive development in scientific procedures. Public health has made such progress in the past century that the application of the acquired knowledge has made it possible to reduce the harmful effects of illness. The life-span has considerably increased. Swedish

done by the action of Massachusetts and Ontario in forming the League Francais de Sante du Canada, Milieu de Sante. One organization was founded in order to support the professional interests of the workers which amount to a few thousand concentrated throughout the regions and territories of the province. Our association is interested in the major problem of public health in this province. We have studied this problem in all concerns, professional, social, scientific and legal aspects and we have never feared to take a position when the interests of public health were involved. The association, therefore, is devoted to the cause of public health, and the medical profession, whenever our competence and our experience is required, we are at the disposal of the governments, of hospital services, and of medical and prevential institutions dealing with public health particularly when a task which calls for our knowledge, concerns our responsibilities and involves ourselves on the basis of the Order-in-Council of 1941, 6b, which was passed by this Canadian Government the 5th of June, 1941.

We hope to furnish valid contributions to the inquiry presently being conducted. The main objective is to deal with the resources of health for the population of the Province of Quebec.

The developments in our society has led to an impressive development in scientific procedures. Public health has made such progress in the past century that the application of the sciences of knowledge has made possible to assure the benefit of some of life as.

The differences and contradictory interests, Quebec

statistics concerning longevity show that from the average age of thirty-four years, which applies to the 1755 to 1766 period, the average life-span reached forty-one years. During 1826 to 1840, much more rapid progress was made thereafter, and the life expectancy increased to fifty-seven in 1911 to 1920, and to sixty-six in 1936 to 1940, the average life-span was in 1900 forty-eight years for the male sex and fifty-one years for the female sex.

The figures were respectively sixty-five and seventy-one years in 1948; according to the mortality tables, in 1900 to 1902 only three-quarters of the new-born children could expect to reach the age of twenty-five years, whereas the same proportion could expect to reach the age of sixty-seven years in 1944.

The raising of the average life-span and the considerable reduction of the mortality rate have made it possible for a greater number of children to reach adult age, and has made it possible for a greater number of mothers to survive their period of fertility and maternity, and has made it possible for a greater number of adult workers to live throughout their entire period of productivity.

The sanitary measures which have given such health, have required considerable expenditure, but these expenditures were considered a very important investment, because they were recovered in the form of increasing human capital available. This is true because the present income of an individual is proportionately twice as high as in 1899.

statistics concerning longevity show that from the average age of thirty-four years, which prevailed in the 1750 to 1760 period, the average life-span reached forty-one years. During 1920 to 1930, much more rapid progress was made therein; the life expectancy increased to fifty-seven in 1920 to 1930, and to sixty-six in 1936 to 1940, the age life-span was in 1920, forty-eight years for the male sex and fifty-one years for the female sex.

and seventy-one years in 1940; according to the mortality series, in 1920 to 1930 only three-quarters of the new-born children could expect to reach the age of twenty-five years, whereas the same proportion could expect to reach the age of sixty-seven years in 1940.

The raising of the average life-span and the considerable reduction of the mortality rate have made it possible for a greater number of children to see a adult age, and has made it possible for a greater number of women to survive beyond the period of fertility and maternity, and has made it possible for a greater number of adult persons to live throughout their entire period of productivity.

The sanitary measures which have given such results, have required considerable expenditure, but these expenditures were considered a very important investment, because they were recovered in the form of increasing human capital available. This is true because the present income of an individual is proportionately more as high as in 1920.

Despite the reduction in the mortality rates, this reduction in illness, and the resulting reduction in absenteeism has produced an increasing productivity, both on the individual as well as on the collective basis.

Nevertheless, despite all this, individuals are not --- many individuals are not in a position to pay the costs of illness. This constitutes a factor of insecurity for a great many people. One class in our society therefore is placed in the paradoxical and inadmissible situation of not being able to benefit from modern techniques and modern progress attained in the field of health, and it is in conformity with public welfare and public health that this brief has been submitted.

In order to attain more surely our objective, and in order that this objective should correspond to the moral aspect and the social needs of our population, we believe this question should be considered. Under the constitutional aspect, the social aspect, and the medical aspect, and the public and economic aspect. On the basis of historical fact, on court decisions, on legal opininns, and on statements made by our statesmen, this brief will endeavour to prove that health is a matter for provincial authorities.

It could be disadvantageous for individuals and this society if we were to endeavour to find simple solutions by nationalization and state control which would provide security, but without participation of the individual, and without the contribution of the citizen. Our Association is fully aware of the demands

Despite the resources in the community, this reduction in illness, and the resulting reduction in absenteeism has promoted an increased productivity, both on the individual as well as on the collective basis.

Nevertheless, despite all this, individuals are not --- many that idealists are not in a position to pay the costs of illness. This constitutes a barrier of inequality for a great many people. Are we in our society therefore to proceed in this paradoxical, and inconsistent situation of not being able to benefit from modern techniques and modern programs contained in the field, and it is in conformity with good welfare and public health that this point has been mentioned.

In order to achieve more nearly our objectives, and in order that our objectives should correspond to the moral concept and the needs, needs of our population, we believe this question should be considered. Under the constitutional aspect, the social aspect, and the medical aspect, and the public and economic aspect. On the basis of historical fact, on sound decisions, on legal principles, and on the benefits made by our statesmen, this brief will endeavour to prove that health is a matter for provincial authorities.

It could be discussed from legal circles and this society is to make or preserve the human single individual by rehabilitation and where control which could provide security, but rather the protection of the individual and increase the conservation of the human. The innovation is still aware of the demands

of the public and contemplates a plan which will take into account the ability of the individual to pay the cost, while recognizing that the cost should be proportional to their ability and the rights both of society and the medical profession.

If illness and the expenses that it involves and causes, if it is a factor of security, if it is essential to establish a balance between the ever-increasing cost of illness and the demands of those who are responsible for public health, we must nevertheless stress that fees for medical treatment given to patients by doctors are only one portion, and not the largest portion of the costs incurred by the illness.

Without wishing in any way to discredit the fee system, we consider in view of the complex nature of any evaluation of medical services, because there are very valuable elements involved, we think it is desirable to ensure the quality of medical care and respect the principle of fee for service. To take into account the economic conditions at present prevailing and forecast for the next few decades, we are against the establishment of State medicine. We are, however, in favour of the establishment of an insurance plan giving the best service to the population while safeguarding the freedom of the medical profession.

According to our views of medical problems of today and tomorrow, we believe that a mutual type of plan, with contributory elements acceptable to all would be the best, operated on an independent basis and private enterprise would participate in it. It

of the public and contemplates a plan which will take into account the ability of the individual to pay the cost, while recognizing that the cost should be proportional to their ability and the status both of society and the medical profession.

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Without wrecking in any way to discredit the fee system, we consider in view of the complex nature of any evaluation of medical services, because there are very variable elements involved, we think it is desirable to ensure the quality of medical care and respect the principle of fee for service. To take into account the economic conditions at present prevailing and forecast for the next few decades, we are against the establishment of State medicine. We are, however, in favour of the establishment of an insurance plan ensuring the best service to the population while safe-guarding the freedom of the medical profession.

According to our views of medical problems of today and tomorrow, we believe that a mutual type of plan, with contributory elements acceptable to all would be the best, operated on an independent basis and private enterprise would participate in it. It

would provide total protection against the degrees involved in illness, and the State would only play a supplementary role, thus escaping from excessive financial risks.

Ladies and gentlemen of the Commission, that is a summary of the brief which we have the honour and privilege to submit to you.

THE CHAIRMAN: Thank you, Dr. Leger. I would like to say, Dr. Leger, that the inclusion in your brief of so much in relation to the Constitutional aspect, you have devoted a substantial part, thirty-eight pages of the brief to this aspect of the problem, that it is obvious that it appears to play an important part in your thinking in terms of the rights and powers of the province, and the rights and powers of the federal government, and the summary of the jurisprudence on this subject which you have included in your brief is an extremely interesting one, and a valuable one, and one which we are going to read with a great deal of interest, and with much profit.

I think I would be justified in repeating here what I have had occasion to say on two or three occasions previously, but particularly at the preliminary hearing that we had in Ottawa on September 27th, in which I dealt with the fact that in the Province of Quebec the position was being taken that the question of health services was one solely within the jurisdiction of the province, and at that time, and again in Quebec City, last Monday, that was the Monday a week ago, I had occasion to repeat that it was not the

would provide total protection against the dangers involved in fishing, and the State would only play a supplementary role, also encouraging non excessive fishing-clubs there.

Ladies and gentlemen of the Commission, that is a summary of the brief which we have the honour and privilege to submit to you.

THE CHAIRMAN: Thank you, Dr. Jager. I would like to say, Dr. Jager, that the treatment in your brief of so much in relation to the constitutional aspect, you have devoted a substantial part, thirty-eight pages of the brief to this aspect of the problem, that it is obvious that it appears to play an important part in your thinking in terms of the rights and powers of the province, and the rights and powers of the federal government, and the answers of the jurisdiction on this subject which you have included in your brief is an extremely interesting one, and a valuable one, and one which we are going to read with a great deal of interest, and with much profit.

I think I would be justified in repeating here what I have had occasion to say on two or three occasions previously, and particularly at the preliminary hearing that we had in Ottawa on September 27th, in which I dealt with the fact that in the provinces of where the population was being taken that the question of Indian servitude was one solely within the jurisdiction of the province, and at that time, and again in Vancouver, last Monday, there was the Monday, I was

intention of this Commission to interfere with or to ignore in any way the provincial rights, and I went on to say that the constitutional questions raised respecting the jurisdiction of the province and of the Dominion in this way are questions which are beyond the competence of this Commission to determine, and fall for determination by higher governmental bodies.

The matter of of a health services programme is one that naturally is going to take some time, in which the constitutional aspects may be worked out to the satisfaction of everybody, but whether the public of Canada is prepared to wait while the constitutional lawyers solve their difficulties, may be another question, and in that regard it is of great help to this Commission that, appreciating the position being taken in this province, and in which you gentlemen say you agree, that nevertheless, you have come forward with your own ideas, as to how a programme should be instituted, and the principles which should govern the establishment of any such programme.

The fact that there may be no questions being put does not indicate in any way any lack of interest. You will appreciate that we had the National organization, or this is the Filiale du Quebec, we had the parent organization, shall I say, before us, in which all the questions now being treated were more fully discussed, and in that sense, it would be repetition to go through the same procedure again, because we will accept that your views will not be very different from those put forward by the parent organization, so

inception of this Commission to interfere with or to ignore in any way the provincial rights, and I want to

respecting the jurisdiction of the province and of the Dominion in this way are questions which are beyond the competence of this Commission to determine, and will for determination by higher governmental bodies.

The matter of of a health services programme is one most seriously to press on the Dominion, in which the constitutional aspects may be worked out to the satisfaction of everybody, but whether the public of Canada is prepared to wait while the constitutional lawyers solve their difficulties, may be another question, and in that regard it is of great help to this Commission that, appreciating the position being taken in this province, and in which you respectfully may agree, that nevertheless, you have come forward with your own ideas, as to how a programme should be instituted, and the principles which should govern the establishment of any such programme.

The fact that there may be no questions being put does not indicate in any way any lack of interest. You will appreciate that we had the National organization, or this is the Ligue du Quebec, we had the health organization, shall I say, before us, in which all the questions now being treated were more fully discussed, and in more detail. It would seem a pity to go through the same procedure again, because we think a copy that you have will not be more different from those put forward by the national organization, to

I want to thank you very kindly for the time, the effort, that was put into your preparation of this brief, for the views that you have expressed, the detail with which you have gone into so many aspects of the subject, and this brief will be studied in very much detail by our Research Staff, and will be available to us along with the other submissions that we have had, in trying to find a solution, if there is one, or perhaps to formulate a plan, if that is the decision that one should be formulated, because we have no mandate to do one thing as distinct from another, or to come forward with any particular, or any plan and say the subject is entirely a wide-open one, the question is wide open, and until we have had an opportunity to have received the submissions from all the provinces in Canada, and have received the result of the studies which we have commissioned, the question as to what will be done must necessarily remain an open one, but in any final consideration the views that you have put forward will have our attention. Thank you very much.

DR. LEGER: Thank you very much, Mr. Chairman and ladies and gentlemen for your kind attention.

I want to thank you very kindly for the same, the effort that was put into your preparation of this paper, for the views that you have expressed. The ideas with which you have gone into so many aspects of the subject, and this brief will be studied in very much detail by our Research Staff, and will be available to us along with the other submissions that we have had, in trying to find a solution, if there is one, or perhaps to formulate a plan, if that is the decision that one should be formulated, because we have to decide to do one thing as distinct from another, or to move forward with any particular, or any plan and say the subject is entirely a wide-open one. The question is wide open, and until we have had an opportunity to have received the submissions from all the provinces in Canada, and have received the views of the students which we have commissioned, our question as to what will be done must necessarily remain an open one, but in any final consideration the views that you have put forward will have our attention. Thank you very much.

Mr. LEWIS: Thank you very much, Mr. Chairman and Jackie and gentlemen for your time and attention.

SUBMISSION

of

HOPITAL ST. LUC

Appearances:

Dr. J. P. Laplante

THE CHAIRMAN: Dr. Laplante.

DR. LAPLANTE: Mr. President, I am very pleased to be in front of the Commission again. I haven't got any special brief to present, but I am very happy to be of assistance in any questions you might have.

So far as bringing up anything myself, I might bring up a few things that were brought up yesterday morning when I was representing and speaking in the name of the Association of Hospital Administrators for the Province of Quebec. At that time certain things came up that hadn't been discussed, and I didn't want to speak in the name of the Association, but I would be very happy now to make a few comments on some of the points which seemed to interest the Commission.

THE CHAIRMAN: We are very pleased to have your observations, Dr. Laplante.

DR. LAPLANTE: One of them would be the question of general practitioners in hospitals.

THE CHAIRMAN: And you were here this afternoon when I was haltingly, perhaps imperfectly, discussing the same subject, so you are perfectly free to comment on anything I said as well.

[illegible]

[illegible]

DR. [illegible]: Mr. President, I am very pleased to be in front of the Commission again. I haven't got any several brief to present, but I am very happy to be of assistance in any questions you might have.

So far as bringing up anything myself I might bring up a few things that were brought up yesterday morning when I was representing and speaking in the name of the Association of Hospital Administrators for the Provinces of Quebec. At that time certain things came up that hadn't been discussed, and I didn't want to speak in the name of the Association, but I would be very happy now to make a few comments on some of the points which seemed to concern the Commission.

THE CHAIRMAN: We are very pleased to have your observations, Dr. Lafontaine.

Mr. [illegible]: One of them might be the question of general practitioners in hospitals.

THE CHAIRMAN: And you were here all afternoon when I was [illegible], perhaps inadvertently, concerning the same subject, so you are particularly free to comment on anything I said or not.

DR. LAPLANTE: Well, this feeling I have about the general practitioners, having been a general practitioner myself, is that they certainly should have access to hospitals. However, generally speaking, a general pratitioner generally wants to have access to the hospital to bring in his patients, but unfortunately, they do not seem to find enough time to contribute something to the medical staff of the hospital, and going by the standards of the accreditation, which after all have been proved to be effective for forty years, I take the attitude that the general practitioner should be admitted to the general hospital if they are willing and ready to contribute something to the hospital, to the medical staff, and secondly, have their privileges delineated in such a way that they come within their classification, and that their work should be well supervised.

With this in mind, I don't think, except with higher teaching hospitals, I mean, larger teaching hospitals where practically all the staff are specialists, I would say that the general practitioners are accepted and welcome.

In the last two hospitals that I had anything to do with, the present one and the one before, general practitioners were practicing there, and as long as those regulations were followed, I think everybody was happy, so it is to my mind quite possible to have general practitioners working in hospitals, and I think that they should.

The other point that was brought up was

DR. LAZZARTO: Well, this feeling I have about the general practitioner, having been a general practitioner myself, is that they certainly should have access to hospitals. However, generally speaking, a general practitioner generally wants to have access to the hospital to bring in his patients, but unfortunately they do not seem to find enough time to contribute something to the medical staff of the hospital, and going by the standards of the accreditation, which often all have been proved to be effective for fifty years, I take the attitude that the general practitioner should be admitted to the general hospital if they are willing and ready to contribute something to the hospital, to the medical staff, and secondly, have their activities delineated in such a way that they are within their specification, and that their work should be well supervised.

From this in mind, I don't think, except with higher teaching hospitals, I mean, larger teaching hospitals where practically all the staff are specialists, I would say that the general practitioners are accepted and welcome.

In the last two hospitals that I was working to do with, the present one and the one before, general practitioners were practicing there, and as long as those regulations were followed, I think everybody was happy, so it is to my mind quite possible to have general practitioners working in hospitals, and I think that the, specia.

The other point that was brought up was

the question ---

THE CHAIRMAN: Just before you leave that, Dr. Laplante. We had the general practitioners voice what you might call a complaint in that respect. Is there any recommendation that might be made which would ameliorate the condition, which would obviate this feeling of inferiority or whatever it is that the general practitioner seems to feel in relation to hospital practice.

DR. LAPLANTE: Well, going back to the standards of accreditation, I would say that the general practitioner could be admitted to hospitals. He should be given to understand that as a clinical department they exist as such, but if they do treat a case of medicine, they should come under the chief of medicine of the department of medicine or surgery or obstetrics, and they should contribute something by doing some work with the different committees, and as many hospitals are doing, and is recommended by the Accreditation Commission, would be for them to handle the patients in the out-patient departments.

THE CHAIRMAN: This probably points up the historical difference in the development of medical practice in North America, as distinct from England, that the general practitioner in England we know just does not go near the hospital. He refers if it is a case for hospitalization, the patient is referred to a doctor on the hospital staff, and that is accepted, that is the historical development of medical practice in England. Our historical development in America was that every

doctor, they were all general practitioners in the main, in the beginning, that every doctor had sort of as of right the opportunity of bringing his patients to a hospital, and treating them in a hospital, but the development of specialization in America appears to be shouldering the general practitioner out of the hospital and into the historical context of English medicine.

Do you see that developing, is that what is going on?

DR. LAPLANTE: Well, I wouldn't say so, sir, as far as the ---

THE CHAIRMAN: I mean in the Metropolitan areas. I know this is not going on out in the rural areas.

DR. LAPLANTE: Well, I don't know. I know of many smaller hospitals who have general practitioners there. On the other hand, if we talk --- well, taking Montreal, the larger teaching hospitals, they wouldn't have enough staff. It is presently so large that they wouldn't have enough beds for the general practitioner.

THE CHAIRMAN: Are we seeing this thing developing, not because of ill-will or wanting to do it, but simply as an evolution in the practice of medicine?

DR. LAPLANTE: Would you say evolution in the last few years or the last fifty years?

THE CHAIRMAN: Yes, as specialization becomes more universal, and as the specialists more and more control the medical practice within the hospital walls?

DR. LAPLANTE: Well, I would say this is right as far as the large teaching hospitals, because

they were all general practitioners in the main. In the beginning, there was a major issue of as of right the opportunity of being referred to a hospital, and treating them in a journal. But the development of specialization in medicine appears to be abolishing the general practitioner out of the medical and into the biological concept of medicine nowadays.

Do you see that developing, in that what is going on?

DR. LAPRAVOTE: Well, I would say, sir, as far as the ---

THE CHAIRMAN: I mean in the metropolitan areas. I know that is not going on out in the rural areas.

DR. LAPRAVOTE: Well, I don't know. I know of many smaller hospitals who have received practitioners there. On the other hand, if we take --- well, taking Montreal, the large teaching hospitals, they wouldn't have enough staff. It is presently so large that they wouldn't have enough beds for the general practitioner.

THE CHAIRMAN: Are we seeing this shift developing, not because of his will or anything to do with it, but simply as an evolution in the practice of medicine?

DR. LAPRAVOTE: Would you say evolution in the last few years or the last fifty years?

THE CHAIRMAN: Yes, as specialization becomes more universal, and as the specialtyness gets more ahead of the medical practice within the medical profession?

DR. LAPRAVOTE: Well, I would say that it would be as far as the large teaching hospitals, because

there, with the idea of giving the very best possible treatment for the patient, well, then if he is treated by a specialist less is bound to be missed as far as he is concerned.

THE CHAIRMAN: Would you go on, I mean, if you have any other observations?

DR. LAPLANTE: The other point that was brought up yesterday morning, the questinn of out-patient clinics, and my own views are these, that certainly building hospitals at fifteen to twenty thousand dollars a bed, spending another three thousand dollars to a bed to equip that hospital, and then close to five thousand dollars a year to maintain that hospital, I don't think we should treat tonsillitis and grippe and minor ailments in those beds.

In the old days, an awful lot of good medicine was done at home, and those that can certainly attend to the doctor's office, and they haven't got any money, can attend to the out-patient department, but I feel a great deal of that can be done on an out-patient basis. X-ray examinations, electrocardiographs, laboratory work, consultations between different specialists, can be done on an out-patient clinic basis. Of course, those who can afford to pay, or have an insurance and are not indigent any more, they wouldn't be classed as the old idea of out-patient department, patients who are indigents.

Then the doctors would say we have got to make our living. At the present time it is pretty hard for a doctor to go out and make, say, twenty calls a day

[illegible], with the idea of giving the very best possible treatment for the patient, well, even if he is treated by a specialist [illegible] be taken to be missed as far as he is [illegible].

THE CHAIRMAN: Would you go on, I mean, if you have any other observations?

DR. [illegible]: The other point that was brought up yesterday, regarding the question of out-patient clinics, and my own view was that generally building hospitals at fifteen to twenty thousand dollars a bed, spending another three thousand dollars a bed to equip that hospital, and then close it to live [illegible] patients a year to maintain that hospital, I don't think we should treat hospitals and equipment almost as in those days.

In the old days, an awful lot of good medicine was done at home, and those that can certainly afford to the doctor's office, and they [illegible] money, can attend to the out-patient department, but I [illegible].

I may mention that, [illegible] laboratory work, consultations between different specialists, can be done on an out-patient clinic basis. Of course, those who can afford to pay, or have an insurance and are not indigent any more, they would be charged as the old idea of out-patient department, [illegible].

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with the traffic and the cities, it is much more convenient to go to one place and park his car and see twenty patients in the hospital, but is it the best way to do it? And spending an awful lot of money treating patients in hospitals. Then possibly a home care service by regions of a city, for instance, where you would have the medical service, nursing service, social service, physiotherapy and dietary and whatever might be needed, where they could go and visit those patients, I think it could very well be done more economically than building hospitals and bringing all those patients in there for that purpose.

THE CHAIRMAN: Well, even where the patients are in hospitals, do you see the home care service as being an aid in getting people out of a hospital sooner than they are being discharged now?

DR. LAPLANTE: Certainly, and in certain places where it has been tried it has been most successful, and I am sure you all know about Montefiore, New York, which proved to be excellent.

THE CHAIRMAN: A question Miss Girard put yesterday afternoon, with all the publicity emanating from the Montefiore project, why has it not been duplicated in other places? In your hospital administration work have you run across any answer to that? That a thing that was so successful in one area has not been copied anywhere else to a great degree?

DR. LAPLANTE: That is true. I don't know of many places where they do have it, or the reasons why not. Here in Montreal one was started and it is

with the traffic and the cities, it is much more convenient to go to one place and park his car and see twenty patients in the hospital, but is it the best way to do it? And spending an awful lot of money treating patients in hospitals. Then possibly a home care service by regions of a city, for instance, where you would have the medical service, nursing service, social service, physiotherapy and dietary and whatever might be needed, where they could go and visit those patients. I think it could very well be done more economically than building hospitals and bringing all those patients in there for that purpose.

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THE CHAIRMAN: A question Miss Girard put yesterday afternoon, with all the publicity emanating from the Montefiore project, why has it not been duplicated for other diseases? In your hospital administration work have you run across any answer to that? That's a thing that was so successful in one area has not been copied anywhere else to a great degree?

DR. LAMALICE: That is true. I don't know why not. Here in Montreal one has site-tested it in

fairly successful, but it is not a large one, and that is the Herbert Reddy Memorial Hospital. I would guess, merely guess, that it is not convenient for the doctors to organize such a thing.

THE CHAIRMAN: Do you mean convenient because they are too busy, or convenient because it would mean more work for them?

DR. LAPLANTE: It is quite an organization, and one doctor cannot do it himself. It takes a team and it has got to be based on a hospital to my own mind, or to a health clinic.

THE CHAIRMAN: We heard there was a pilot project going on in the university hospital in Saskatoon.

DR. LAPLANTE: Yes, I understand there is, not very long ago though. They haven't started very long.

THE CHAIRMAN: No, it was just recently inaugurated. Have you any opinion, doctor, to offer on this matter of the necessity for convalescent homes and rehabilitation services in relation to the utilization of hospital beds? That is, whether the time necessarily spent in hospital by any patient, by some patients, might be shortened by having available convalescent beds and rehabilitation services?

DR. LAPLANTE: Most certainly, and especially about rehabilitation services because certainly in that terminology we have more and more of that developing since automobile days and skiing. There is certainly a great deal to be gained by having the patient

fairly successful, but it is not a large one, and that

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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spent in hospital by any patient, by some patients, might

be shortened by having available convalescent beds and

[illegible]

DR. LAPLANTE: Most essentially, and

[illegible]

[illegible]

[illegible]

[illegible]

start as soon as he can in his rehabilitation by physical medicine, physiotherapy, and that, most of the time can be carried out just as well on an out-patient basis as in the hospital. As far as convalescence is concerned, there could be convalescent work close to the hospital. If we are going to cut down patient days, say, from ten to seven or eight post operative for elective surgery, I still think within the ten days that patient has to be under pretty close supervision, medical supervision, and therefore, if the patient is sent out too far and he is left to the observation of a new group of nurses or nurses assistants in the so-called convalescent home, I wouldn't think it would be desirable. As far as chronic patients are concerned, that is a different story, although certainly we should have some of those in order to liberate the active treatment beds of general hospitals.

THE CHAIRMAN: Dr. Laplante, you are here as we know at our invitation to answer certain questions that we feel hospital administrators are best qualified to deal with and that is this matter of the utilization of present hospital beds, of hospital facilities and so forth. What about the utilization of hospital facilities being adversely affected through shortages of staff or through shortages of qualified staff?

DR. LAPLANTE: Well, I think it is quite a problem because at the present time even for the present number of beds we have, I don't think we have enough specialists, with a few exceptions. We have lots of surgeons, lots of orthopaedists, lots of internal

assist as soon as he can in his rehabilitation by physical medicine, physiotherapy, and that most of the time can be carried out just as well on an out-patient basis as in the hospital. As far as convalescence is concerned, there could be convalescent work close to the hospital. If we are going to cut down patient days, say, from ten to seven or eight post operative for elective surgery, I still think within the ten days that patient has to be under pretty close supervision, medical supervision.

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THE CHAIRMAN: Dr. Ingalls, you are here as we know at our invitation to answer certain questions that we feel hospital administrators are best qualified to deal with and that is this matter of the utilization of present hospital beds, or hospital facilities and so forth. What about the centralization of hospital facilities being adversely affected through shortages of staff or enough numbers of qualified staff?

DR. INGALLS: Well, I think it is quite a problem because at the present time even for the present number of beds we have, I don't think we have enough specialists, with a few exceptions. We have lots of surgeons, lots of orthopaedists, lots of internal

medicine, but at the present time we don't have enough pathologists. We don't have enough radiologists, and then in the next plane, we haven't got enough nurses certainly, to say nothing of the specialized nurses, specialized psychiatrict, operating room, paediatric or obstetric. We haven't got enough technicians for the laboratory or x-ray departments.

A study was done last year or so as far as radiology technicians were concerned in this province. We need about one thousand to give good service wherever x-ray machines are being operated. There are only three hundred to three hundred and fifty technicians. I don't know if that is the same picture everywhere else, in the other provinces, but certainly we are short of them.

THE CHAIRMAN: It is the same complaint, but maybe not in the same proportions. It is quite a problem, and the philosophy of this is this, whenever we used to have nurses, for instance, to do everything a patient required to be done to him, now we have nurses doing only the higher plane of nursing duties today and we train assistants.

DR. LAPLANTE: We train some of those today, handling of babies in the nursery, and this they do well. As far as specialized nurses in the operating room -- I don't know any reason why we can't train technicians which will do just as well in helping the surgeon to operate in handing him the instruments and keeping things sterile, without him having to learn the things, simple nursing duties like giving

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DR. WALLACE: We train some of those today, training of orderlies in our nursery, and this they do well. As far as specialized nurses in the operating room -- I don't know any reason why we can't train technicians which will do just as well in helping the surgeon to operate -- anything like that -- and keeping higher status, without the nurses and so learn the things. Simple nursing duties like giving

enemas. He wouldn't have to learn that. We could train him. During the war we certainly had some marvelous technicians we trained from ordinary orderlies, and they could put a needle in a vein to give a transfusion a lot better than some doctors I have seen try to do it.

My philosphy would be to train people to help in the nursing without knowing the whole of the nursing field. It might be the same with technicians, because, even in the laboratory today we have some assistant technicians doing nothing but dishwashing, some with a Ph.D. in biochemistry or bacteriology. You have all these different types of trained people in between those two extremes. I don't think we have enough, and it will take a long time to have enough.

The same thing with the social service worker, the physiotherapist, the occupational therapist, the dietitians. We have to find some way, if we can't have fully trained people to do all the work to be done, we will have to grade the type of job to be done in each one of these specialties, and give that to those who are fully trained, and train assistants to do part of the other work, the lower echelon.

THE CHAIRMAN: Thank you. Any questions Dr. Baltzan?

COMMISSIONER BALTZAN: Yes, Dr. Laplante, do you find a new situation confronting you more than ever before, for instance, the doctors' appraisal of the things which indicate the need for the patient to go into the hospital and assuming that that being the case and there is room available, there is no problem about it. The

emergency. He wouldn't have to learn that. We could teach him. During the war we certainly had some marvelous technicians we trained from ordinary civilians, and they could put a needle in a vein to give a transfusion a lot better than some doctors I have seen try to do it.

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THE CHAIRMAN: Thank you. Any questions Dr. Ishikawa?

[illegible] BARTZAN: Yes, Dr. Bagla, do you find a new education confronting you more than ever before, for instance, the doctors' appraisal of the things which indicate the need for the patient to go into the [illegible] in room available, there is no problem about it. The

main thing on the opposite side, there is a question of public demand for admission to the hospital, that the public will say and do say -- we hear it in ever place. There is public demand saying it is better for me to go into the hospital. I will get results quicker and I haven't got the accommodation at home, so there is on the one hand the needs, medical needs, and on the other, the element of public demand for this accommodation. Are you confronted with -- is it confronting you more than ten or fifteen years ago?

DR. LAPLANTE: Yes, sir, certainly, because -- I am not very old but -----

COMMISSIONER BALTZAN: That is why I didn't mention thirty years ago.

DR. LAPLANTE: Thirty years ago when I was beginning my career as a doctor, people weren't so anxious to go to the hospital, and at that time I heard that not very many years before that people wouldn't go to the hospital, and that is why the mortality rate was so high. People would only decide to go to the hospital when they didn't have enough strength to resist.

Yes, we do get quite a bit of that demand. In the case that you put up, the patient must want to go to the hospital because he feels he will be treated better and he may not have that at home. Possibly home care will answer that, in certain cases, anyway.

COMMISSIONER BALTZAN: Once it is provided and once it is proven to him that the results will be equally as good?

DR. LAPLANTE: That is right, and there

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DR. LAFLAMME: Yes, sir, certainly.

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DR. LAFLAMME: That is right, and there

is another group, I even heard doctors say, I know I shouldn't, it is not absolutely necessary for that patient to go in the hospital, but the patient wants to, what can I do. He says, if I don't bring him in, he will come to my office and he wouldn't take the proper drugs, maybe he hasn't got the money to buy it, and he wouldn't get any better because he doesn't come in. I feel personally this by itself is not reason to bring them into the hospital, but some other arrangements could be made so that person may, through social service and some other social agency obtain the necessary help in the house, some help with children, get the necessary food, get the necessary medication. That could be done without the patient having to go to the hospital, but at the present, that is the only solution that is handy, and therefore, they are using it.

COMMISSIONER BALTZAN: Too administrators and medical teams are in the position of having to, at least, to satisfy public demand, not to the fullest extent they would want, but there is that element that is confronting you as administrator quite frequently?

DR. LAPLANTE: Oh, yes.

COMMISSIONER BALTZAN: That cannot be entirely disregarded?

DR. LAPLANTE: No, no. I agree with you. Some of it is very useful. There is some abuse. There is some that is very useful.

COMMISSIONER BALTZAN: Just one more thing, we are very much interested in the length of stay of patients in your hospitals. We have heard some very

in another group, I even heard Commissioner say, I know I shouldn't, it's not a [illegible] for such patients to go in the hospital, but the patient wants to, what can I do. He says, if I won't judge him in, he will come to my office and he wouldn't take the proper drugs, maybe he hasn't got the money to buy it, and he wouldn't get any better because he doesn't come in. I feel personally this by itself is not reason to bring them into the hospital, but some other arrangements could be made so that person may, through social service and some other social agency obtain the necessary help in the house, some help with children, get the necessary food, get the necessary medication. That could be done without the patient having to go to the hospital, but at the present, that is the only solution that is seen, and therefore, they are using it.

COMMISSIONER CARTER: Too economists and medical teams are in the position of having to, at least, to satisfy public demand, not to the fullest extent they would work, but there is that element that is confronting you as administrator quite frequently?

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COMMISSIONER BARTRAM: Just cannot be entirely disregarded?

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COMMISSIONER CARTER: Just one more thing, we are very much interested in the length of stay of patients in your hospitals. We have heard some very

good reports about that. The reason for that is not so much the administrators alone or the doctors alone, but today, the patient gets out faster than before. Isn't there another reason why there has been a steady decline in the number of days the patient stays in the hospital? I refer, for instance, to the immediate fact of the length of stay by the introduction of early ambulatory treatment of post-operative cases. A hernia case was kept in bed for at least two weeks and some three weeks, and now, they are up on the second day. That is one of the contributing factors. Of course, there are the results obtained from specific medications. In other words, the results that you are getting in the reduction of your hospital day occupation is the result of a number of factors and not only vigilance?

DR. LAPLANTE: That is right.

COMMISSIONER FIRESTONE: Dr. Laplante, there has been a case for increasing use of out-patient facilities to reduce some of the pressure that is put now on available hospital beds in the Province of Quebec. Have you got adequate out-patient facilities to handle the increasing volume of cases?

DR. LAPLANTE: Well, I couldn't speak for all the hospitals, of course, but I feel whatever there is now can be utilized by greater efficiency, to a greater extent and greater efficiency. Yesterday morning, also, the question was brought up, we have very expensive equipment, lots of capital investment in the x-ray department or in the lab. and why use that only a few hours a week.

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DR. LAFAYETTE: That is right.

Where has been a case for increasing use of out-patient facilities to reduce some of the pressure that is put now on available hospital beds in the Province of Quebec, have you got adequate out-patient facilities to handle the increasing volume of cases?

DR. LAFAYETTE: Well, I wouldn't speak for all the hospitals, of course, but I feel whenever there is now can be obtained by ambulatory, by a special out-patient department efficiency. Especially morning, also, the question was brought up we have very expensive equipment like of surgical instruments in the X-ray department, in the lab, and why use such a

COMMISSIONER FIRESTONE: How could you use the facilities more efficiently than you are using them now, and why are you not using them more efficiently now?

DR. LAPLANTE: The matter of organization in many places. If we were to organize along more modern, streamlined methods, possibly, we could. As I mentioned a little while ago, as far as general practitioners, at the present time we haven't got enough doctors to handle out-patients as such, and we haven't got enough internes.

COMMISSIONER FIRESTONE: Why don't you have enough doctors and why can't you get them? We have complaints of the number of doctors that haven't got access to hospitals. Why can't you get more doctors?

DR. LAPLANTE: I feel we could get them if they wanted to give that much time.

COMMISSIONER FIRESTONE: Have you tried to get doctors and have you been refused?

DR. LAPLANTE: No, I can't state any instances.

COMMISSIONER McCUTCHEON: You are saying the general practitioner would like to admit his patients to beds in the hospital but is not too anxious to give, say, two mornings a week to the out-patients?

DR. LAPLANTE: Yes.

COMMISSIONER FIRESTONE: What I would like to understand, and as an administrator you can help me to understand it, are doctors, general practitioners, that wish to have the facilities of the hospital at their

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COMMISSIONER MCCUTCHEON: What I would like to understand, and as an administrator you can help me to understand it, are doctors, general practitioners, that want to have the facilities of the hospital at their

disposal, are they not expected to make some contribution in one form or another to the operation of the hospital? Is there not a relationship between the access to the hospital and the contribution that the doctor will make?

DR. LAPLANTE: That is the way I look at it. That is the way I approach it, but I am not always heard.

COMMISSIONER FIRESTONE: Take the young doctor, the Chairman was talking about, who has graduated, perhaps opening up a practice, and very anxious to be permitted to be part of that circle of doctors. Could some of those young men not be invited to participate in the out-patient clinic work, and then, of course, have the right to admit patients as well? Has any attempt been made to, on an organized basis or is it left to chance?

DR. LAPLANTE: You have a certain amount, certain limit to the number of doctors you may have on the staff of the hospital. The main reason is if a doctor cannot get his patients in he is not interested in going to that hospital at all. If the number of doctors on a hospital staff is such that everybody has to wait too long to get their patients in, and especially if they are juniors and the senior have priority, they wouldn't be too interested in being attached to the hospital. However, in a hospital where the staff is small that is certainly a solution.

COMMISSIONER FIRESTONE: Why should there be discrimination between the senior doctors and junior doctors? I thought the criterion was urgency

in one form or another to the operation of the hospital? Is there not a relationship between the access to the hospital and the contribution that the doctor will make?

DR. LAMPLAMPH: That is the way I look at it. That is the way I approach it, but I am not always heard.

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and the condition of the patient, not seniority of the doctor?

DR. LAPLANTE: Primarily yes, certainly, but those that are not urgent, those that are elective, certainly I think the chief of surgeons and the senior doctors who have given a lot of time for years in teaching and giving time to the hospital, I think they should have priority over the younger man just starting.

COMMISSIONER FIRESTONE: If we could look at it for the moment from the patient's point of view, I appreciate you have to consider the position of your doctors as well, but looking at it from the patient's point of view, is the arrangement that you will admit emergency cases and that other cases will be taken in priority in which the claim was made. In other words, if you have a waiting list you work through it taking the emergency cases and urgent cases and the others as they stand in line? Is that the system or does it depend which doctor you know or use?

DR. LAPLANTE: That system is also in effect in many hospitals I know.

COMMISSIONER FIRESTONE: How about your hospital, sir?

DR. LAPLANTE: The junior man wouldn't have as many patients to bring in and therefore, it is the seniors that will have a larger practice and therefore, will have more patients on the waiting list, and therefore, will bring in more patients.

COMMISSIONER FIRESTONE: But looking at it from the patient's point of view is there any

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DR. LAFLAMME: Primarily yes, certainly but those that are not urgent, those that are elective, certainly I think the chief of surgeons and the senior doctors who have given a lot of time for years in teaching and giving time to the hospital. I think they should have priority over the younger men just starting.

COMMISSIONER FERGUSON: If we could look at it for the moment from the patient's point of view, I appreciate you have to consider the convenience of your doctors as well, but looking at it from the patient's point of view, is the arrangement that you will adopt emergency cases and that other cases will be taken in priority in which the claim was made. In other words, if you have a waiting list you work through it taking the emergency cases and urgent cases and the others as they stand in line? Is that the system or does it depend which doctor you know or use?

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COMMISSIONER FERGUSON: Hospital, also?

DR. LAFLAMME: The junior men [illegible] have as many patients to bring in and therefore, it is the seniors that will have a larger practice and therefore, will have more patients on the waiting list, and therefore, will bring in more patients.

COMMISSIONER FERGUSON: But looking at it from the patient's point of view is there any

discrimination against a patient, whether he employs or goes to a senior doctor or junior doctor?

DR. LAPLANTE: No.

COMMISSIONER FIRESTONE: That is exactly the answer I was hoping you would give me. Thank you very much. I have one other question in connection with the use of hospital bed facilities.

You mentioned a case, if I understood you correctly, of a physician who will admit or request admission of his patient to the hospital because the patient told him he couldn't afford to pay for the drugs. Is there any screening process in the hospital which would deal with a case like this?

DR. LAPLANTE: Yes, but if the doctor recommends the patient and says that there is a definite medical need, no matter what he thinks -- on what he bases himself, if he calls it a medical need, and to some doctors the fact that he can't get drugs, cannot buy drugs and he needs drugs, then he will consider that a medical reason. If that is the way he presents it I doubt if the admitting people will tell the doctor we won't take your case.

COMMISSIONER FIRESTONE: Have you not a screening process, rather than the admitting nurse or admitting official, lady or otherwise, haven't you got a medical director who would look at cases like this, and say, I am sorry, we have waiting lists of so many hundred and we cannot take people who can be treated at home?

DR. LAPLANTE: We try to do that. We do that but there is quite a few that get by.

discrimination against a patient, whether he complains or goes to a senior doctor or junior doctor.

DR. [illegible]: No.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible] or a physician [illegible]

[illegible]

[illegible]

would deal with a case like this?

DR. [illegible]: Yes, but if the doctor recommends the patient and says she's there in a definite medical need, no matter what he thinks -- you must be based himself, if he calls it a medical need, and to some doctors the fact that he can't get [illegible], cannot by drugs and he needs drugs, then he will consider that a medical reason. If that is the way he presents it I doubt if the admitting people will tell the doctor we won't take your case.

COMMISSIONER WEBSTER: Have you not a screening process, rather than the admitting nurse or admitting official, lady or otherwise, haven't you got a medical director who would look at cases like this, and say, I am sorry, we have waiting lists of so many hundred and so forth, here really no car be treated at home.

DR. [illegible]: We try to do that, we do that but there is quite a few that get by.

COMMISSIONER FIRESTONE: Quite a few that get by. In other words, initial use of hospital bed facilities, with more screening and provision of other facilities, out-patient provisions, and so on, could be used more effectively; is that the point you are making?

DR. LAPLANTE: Yes, I wouldn't say it is general, but there are some of them. I think at the end of the year if we were computing all the days in the hospital in one province, it would amount to quite a number of hospital days.

THE CHAIRMAN: Any other questions? Thank you very much, Dr. Laplante. We are very anxious as I said, to have the views of the hospital administrators and particularly those experienced in certain areas. We chose your hospital quite intentionally.

The next submission will be that of the International Ladies Garment Workers Union. We will have a short recess.

--- Short recess.

that got by. In other words, initial use of hospital bed facilities, with more screening and provision of other facilities, out-patient care provisions, and so on, could be used more effectively; is that the point you are making?

DR. LAPIANTE: Yes, I would say it is general, but there are some of them. I think at the end of the year if we were computing all the days in the hospital in one province, it would amount to quite a number of hospital days.

Thank you very much, Dr. Lapiante. We are very anxious as I said, to have the views of the hospital administrators and particularly those experienced in certain areas. We chose your hospital quite intentionally.

The next submission will be that of the International Ladies Garment Workers Union. We will have a short recess.

--- Short recess.

SUBMISSION

of the

INTERNATIONAL LADIES' GARMENT WORKERS' UNION

Appearances:

Mr. S. Bresner

Mr. Ed. Bantey.

THE CHAIRMAN: We will come to order and proceed. The submission of the International Ladies' Garment Workers' Union will be exhibit number 237.

--- EXHIBIT NO. 237: Submission of the International Ladies' Garment Workers' Union.

THE CHAIRMAN: Mr. Bresner, do you wish to make a statement, or to summarize your brief in any way, because I think it would be perhaps better if you did give some general statement, but as you prefer.

MR. BRESNER: I will make a few remarks. I am the representative of the International Ladies' Garment Workers' Union.

As outlined in our brief, which I presume you have all read, you have had it at your disposal for a number of weeks, we enjoy today the services of a health centre situated here in Montreal, and as the brief outlines, prior to the health centre we have had a sick benefit fund established by our members here in Montreal for the benefit of our members.

In conjunction with the health centre

Appearances:

Mr. S. Tuesday

Mr. D. Gordon

The CHAIRMAN: We will come to order and proceed. The submission of the International Ladies' Garment Workers' Union will be entitled Exhibit 127.

--- EXHIBIT NO. 127: Submission of the Ladies' Garment Workers' Union.

THE CHAIRMAN: Mr. Tuesday, do you wish to make a statement, or to summarize your brief in any way, because I think it would be perhaps better if you did give some general statement, but as you prefer.

MR. TUESDAY: I will make a few remarks. I am the representative of the International Ladies' Garment Union.

As outlined in our brief, during I presume you have all read, you have had it at your disposal for a number of weeks, we deploy today the services of a health centre situated here in Montreal, and as the Minister of Labour, prior to the benefit centre we have had a plan here, it has established by our members that it is required for the benefit of our members.

In conjunction with the health centre

we found that we have helped our membership, which comprises approximately twelve thousand members here in Montreal to the extent of giving them a diagnostic check on their health. At the same time we have helped them in times of need, when these people were sick, and we have clarified ----

THE CHAIRMAN: Helped them, Mr. Bresner, besides the hospital and the medical bills?

MR. BRESNER: Yes, as a matter of fact, if I may emphasize on that, I believe it would be interesting to note at the present time our members receive sick benefits at the rate of $21.00 a week for the period of thirteen weeks. That is female members. Our male members receive $24.00 a week for a maximum period of thirteen weeks. We also pay surgical fees, fifty per cent, with a maximum of $100.00. We pay anaesthetists' fees to a maximum of $25.00. We also pay physicians' fees, of $3.00 per day, with a maximum of fifteen days when the patient or member is hospitalized. We also have optical benefits, $10.00 per annum, towards the cost of glasses.

Of course, you must realize that our funds are limited, and we have to guide and judge ourselves according to the income that we get, which is contributed by the employers, but as our brief points out, although through contractual relations with our employers, were it not for contributions to these various funds, it goes without saying that our employees would receive an equal amount in wages, but we believe that sick benefits are of importance, and a health industry is also benefi.ial

we found that we have helped our membership, which comprises approximately twelve thousand members here in Montreal to the extent of giving them a dispensatory lock on their health. At the same time we have helped them in times of need, when these people were sick, and we have clarified ----

THE CHAIRMAN: Helped them, Mr. Prasser, besides the hospital and the medical bills?

MR. PRASSER: Yes, as a matter of fact, we have provided for sick benefits for a period of thirteen weeks. That is female members. Our male members receive $24.00 a week for a maximum period of thirteen weeks. We also pay surgical fees, fifty per cent, with a maximum of $100.00. We pay anaesthetists' fees to a maximum of $25.00. We also pay

of course, the most realize that they are contributed by the employers, but as our brief points out although through contractual relations with our employers,

e of importance, and a vital industry is also [illegible]

to our employers, who employ these people in making their products, and that is why we also believe in welfare benefits as much as we believe in actual wages.

I would just like to read to you from page 6, the second paragraph:

> "It must be clear to all those concerned with the welfare of low and middle income groups in Canada, whether they be workers or farmers, that our country desperately needs a comprehensive health plan which would not involve any additional burden to the taxpayer. In our opinion, a sound and fair health plan must be based on two principles:
>
> 1) Services must be provided to everyone regardless of income;
>
> 2) The cost must be spread over the community as a whole, based on ability to pay."

I stop there, and just want to stress a point, and emphasize the fact that we feel that the nation as a whole is entitled to a welfare benefit plan, a health plan. It is our contention that a healthy nation is a rich nation.

THE CHAIRMAN: Well now, Mr. Bresner, assuming that Canada would have a national health plan which would cover the various matters that you recommend it should cover, and now, is it fair to say that we would start with this proposition that (a) it must be paid for. I mean, any plan will have to be paid for.

[illegible]

[illegible]

products, and that is why we also believe in welfare benefits as much as we believe in annual wages.

I would just like to read to you from [illegible]

"It must be clear to all those concerned with the welfare of low and middle income groups in Canada, whether they be [illegible]

desperately needs a comprehensive health plan which would not involve any additional burden to the taxpayer. In our opinion, a sound and fair health plan must be based on two principles:

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MR. BRESNER: Correct.

THE CHAIRMAN: I don't think we will have much discussion on that phase, will we? I mean, do you agree with that?

MR. BRESNER: Yes, I agree that it will have to be paid for, but there is also the point --

THE CHAIRMAN: Would you mind if I put the second phase of it?

MR. BRESNER: Yes.

THE CHAIRMAN: Do you recommend that it be paid for on a contributory basis, or by the State? That is, on a combined payment by federal/provincial payment without premium by anyone?

MR. BRESNER: I would recommend that it should be paid by the provincial and federal set-up.

THE CHAIRMAN: And you do not support the contributory plan?

MR. BRESNER: Correct. I cannot agree to the contributory plan.

THE CHAIRMAN: I mean, that is your position I just wanted to get at, and if you wish to make some explanations, I don't want to cut you down at all on it, but to shorten the discussion.

MR. BRESNER: That 's all right.

THE CHAIRMAN: You just read on page 6 that:

"---- our country desperately needs a comprehensive health plan ----"?

MR. BRESNER: Yes.

THE CHAIRMAN: And you say you want that

have much discussion on that phase, will we? I mean, do you agree with that?

MR. HERSHEY: Yes, I agree that it will have to be paid for, but there is also the point --

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MR. HERSHEY: Yes.

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MR. HERSHEY: I would recommend that it should be paid by the provincial and federal set-up.

THE CHAIRMAN: And you do not support the contributory plan?

MR. HERSHEY: Decidedly. I cannot agree to the contributory plan.

THE CHAIRMAN: I mean, that in your position I just wanted to get at, and if you wish to make some explanations, I don't want to cut you down at all on it, but to shorten the discussion.

MR. HERSHEY: That is all right.

THE CHAIRMAN: You just read on page 6 that:

"---- our country deservedly made a comprehensive health plan ---"

THE CHAIRMAN: And you say you want one?

paid by the State, a combination of province and Dominion, that is right?

MR. BRESNER: Yes.

THE CHAIRMAN: Then you go on to say: "---- which would not involve any additional burden to the taxpayer."

MR. BRESNER: Correct.

THE CHAIRMAN: Now, how is the State going to pay it without collecting taxes?

MR. BRESNER: Well, may I say a few words on that?

THE CHAIRMAN: Yes, because I think that would be ---

MR. BRESNER: Although it is true that the money has to come from somewhere, we fully realize that, nevertheless I believe that the money should come from the national treasury.

THE CHAIRMAN: Where does the national treasury get the money?

MR. BRESNER: It gets the money through taxation, corporations, individual taxation, and so forth, and that is where the wording of "ability to pay" comes into this picture.

THE CHAIRMAN: And that is the position you take in this?

MR. BRESNER: Yes.

COMMISSIONER FIRESTONE: Do you mean increased taxes by those that are able to pay?

MR. BRESNER: Not necessarily. At the present time, for example, in Quebec we have the

paid by the States, a combination of provinces and Dominion, that is right?

THE CHAIRMAN: Then you go on to say:

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THE CHAIRMAN: And that is the position you take in this?

MR. BRESSNER: Yes.

COMMISSIONER FINNSTROM: Do you recommend increases taxes by those that are able to pay?

MR. BRESSNER: Not necessarily, at the present time, for example, in Quebec we have the

hospitalization plan where the taxes have not been increased and the funds are coming out of the provincial revenue.

COMMISSIONER FIRESTONE: But you also know that as a result of increased payments this revenue is not keeping pace with increased payments. There is a rather large budget deficit. Would you not feel that somehow these programmes have to be paid for, or would you prefer to borrow every year to pay for current programmes?

MR. BRESNER: Well, deficit budgeting is the latest style today. Everybody operates on deficit budgeting. I am aware that people and corporations eventually have to pay their share in one form or another, but nevertheless I do state again that the ability to pay in some cases, some people do not pay taxes, they don't earn enough to pay taxes, and therefore, their share of the load will be carried along with the rest of the country.

COMMISSIONER FIRESTONE: In other words, those that are able to pay will pay for the programme, and if there is not enough revenue coming in on the basis of the existing taxation system, taxes will have to be raised, but they will be paid by those capable of paying them, on the basis of ability to pay?

MR. BRESNER: Yes.

COMMISSIONER FIRESTONE: That is your attitude?

MR. BRESNER: Correct.

COMMISSIONER FIRESTONE: On page 5,

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words, those that are able to pay will pay for the programme, and if there is not enough revenue coming in on the basis of the existing taxation system, taxes will have to be raised, but they will be paid by those capable of paying them, on the basis of ability to pay?

MR. BRESSNER: Yes.

COMMISSIONER FIRESTONE: That is your attitude.

in the second paragraph you say, and I quote:

"It is shocking to think that, in one of the richest countries in the world, people lack medical care because they do not have the money to pay for it."

Can you submit to the Commission any evidence, any concrete cases, any specific cases, where you know the people in Canada lack medical care, or do not receive medical care because they cannot pay for it?

MR. BRESNER: Well, I don't think at the present time that I am in a position to present any evidence other than just verbal messages that have been brought by our members to the offices of our union.

COMMISSIONER FIRESTONE: What kind of cases have been brought to the attention of the officers of your union?

MR. BRESNER: There were cases where people were sick and application was made to the hospitals, and they had to wait months and months at a time in order to get a bed. There were other instances where some of our members took sick, and the doctor was called, and some prices were as high as fifteen and eighteen dollars per visit. Now, in cases such as these, when an exhorbitant price of fifteen dollars, mind you, it might not be exhorbitant to the individual doctor. It might be his fee, but on the other hand, to the patient who is a worker and does not earn too much salary, to him it is an exorbitant fee, and what happens in the future when they feel sick, they may hesitate in calling a doctor when their life may be at stake, and we feel in cases

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MR. BREWSNER: Well, I don't think at the present time that I am in a position to present any evidence other than just verbal messages that have been brought by our members to the offices of our union.

COMMISSIONER FIRESTONE: Then kind of cases have been brought to the attention of the officers of your union?

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such as this if there was some sort of a medical plan where these people know they can call a doctor and be protected from being fleeced by some of these doctors, their health would be improved.

I go back to our health centre, when it was born about seventeen years ago, there was a reluctance on the part of some of our members to come to our health centre.

THE CHAIRMAN: Even though it was free?

MR. BRESNER: Yes. The reason was they thought, number one, there was an invasion of personal privacy. They thought there was some gimmick behind it, but now some seventy-five per cent of our members use our health centre, and I believe we have saved many lives by this service, which is given to our members free of charge. This is only on a small scale. If this scale was enlarged throughout the country, how many lives would be able to be saved because of this?

COMMISSIONER FIRESTONE: Well, I take it when you speak of people that lack medical care, you are talking of people that either have no incomes, or low incomes, and cannot afford to pay the medical fees to which you refer. Could such people not go to the out-patient clinic of a hospital and get such medical care services free of charge if they are either indigent or medically indigent? Medically indigent being defined as people of low incomes with large families and unable to pay the fees?

MR. BRESNER: I imagine some people probably could go, but we also take into consideration

such as this if there was some sort of a medical plan where these people later they can call a doctor and be protected from being fleeced by some of these doctors their health would be improved.

I go back to our health centre, when it was born about seventeen years ago, there was a reluctance on the part of some of our members to come to our health centre.

THE CHAIRMAN: Even then it was free?

MR. MARSHEN: Yes. The reason was they thought, number one, there was an invasion of personal privacy. They thought there was some ulterior behind it, but now some seventy-five per cent of our members use our health centre, and I believe we have saved many lives by this service, which is given to our members free of charge. This is only on a small scale. If this sort was enlarged throughout the country, how many lives would be able to be saved because of this?

COMMISSIONER FRASTOCK: Well, I take it when you speak of people that lack medical care, you are talking of people that either have no income, or low income, and cannot afford to pay the medical fees to which you refer. Could such people not go to the outpatient clinic of a hospital and get such medical care services free of charge if they are either indigent or medically indigent? Medically indigent being defined as people of low income with large families and unable to pay the fees?

MR. MARSHEN: I have no doubt they could go, but we also take into consideration

the fact that in some cases it is not only a question of diagnostic, or what we do find that a person does not go to see a doctor until actually it might be too late, or until it is an emergency, because you must realize, touching again on our industry, they are all workers, and if they lose a half a day at the clinic, waiting their turn to go in, it is a half a day of their wage, which they cannot sacrifice. Therefore the only time they do go to see a doctor is after working hours, and because of the fees that a doctor charges at home, or during emergency, if they have to call a doctor to their home, the fee is so high that they hesitate in calling a doctor, because of their low earnings. I agree with you.

COMMISSIONER FIRESTONE: In your own health centre what are the visiting hours?

MR. BRESNER: Four to seven.

COMMISSIONER FIRESTONE: So people can go there after work?

MR. BRESNER: Correct.

COMMISSIONER FIRESTONE: On page 6 you make the statement on the top of that page:

"The cost of illness is something for which the average family cannot budget in advance."

MR. BRESNER: Yes.

COMMISSIONER FIRESTONE: What is the evidence for this statement?

MR. BRESNER: The evidence for the statement is, I mean, it is all right for a man who is

the fact that in some cases it is not only a question of diagnosis, or what we do find such a person is not go to see a doctor until actually it might be too late, or with it is an emergency, because you must realize, touching again on our industry, they are all workers, and if they lose a half a day at the clinic, waiting their turn to go in, it is a half a day of their wages, which they cannot sacrifice. Therefore the only time they do go to see a doctor is after working hours, and because of the fees that a doctor charges at home, or during emergency, if they have to call a doctor to their home, the fee is so high that they hesitate in calling a doctor, because of their low earnings. I agree with you.

COMMISSIONER FINNERTY: In your own health centre what are the waiting hours?

COMMISSIONER HEPBURN: No people go there after work.

COMMISSIONER FINNERTY: On page 6 you make the statement on the top of that page:

"The cost of illness is something for which the average family cannot budget in advance."

COMMISSIONER HEPBURN: Have is any evidence for this statement?

MR. [illegible]: The evidence for this statement is, I mean, it is all right for a man who is

operating on a budget, I would say, in the ten thousand dollar a year bracket, maybe he can operate on a budget, but a worker with three or four thousand a year cannot operate on a budget. There is no allowance for it. There is the everyday cost and everyday living, and they go accordingly, because they work from day to day.

COMMISSIONER FIRESTONE: Would you then feel that a family with an income of, say, thirty-five hundred dollars a year or less is really not in a position to look after its own medical bills?

MR. BRESNER: Yes.

COMMISSIONER McCUTCHEON: It is usually able to look after its automobile.

MR. BRESNER: Well, I am not aware of that. I don't think that people in the three thousand dollar bracket can afford an automobile as well. You are going to find, it is true, maybe, irresponsible people in all classes of life, but I don't think it is fair to put the average worker in that particular class of being irresponsible.

THE CHAIRMAN: How is your health centre supported?

MR. BRESNER: Yes, it is supported by contributions, by a health centre fund. The employers of our industry contribute a half of one per cent of the employees' earnings monthly into this fund.

THE CHAIRMAN: So that would be six per cent in a year?

MR. BRESNER: Yes, six per cent a year. As a matter of fact, our 1961 figures, the health centre

operating on a budget. I would say, in the ten thousand dollar a year bracket, maybe he can operate on a budget, but a worker with three or four thousand a year cannot operate on a budget. There is no allowance for it. There is the everyday cost and everyday living, and they go accordingly, because they work from day to day.

COMMISSIONER FIRESTONE: Would you then feel that a family with an income of, say, thirty-five hundred dollars a year or less is really not in a position to look after its own medical bills?

Mr. HERSHEY: Yes.

COMMISSIONER MCCUTCHEON: It is usually able to look after its automobile.

MR. HERSHEY: Well, I am not aware of that. I don't think that people in the three thousand dollar bracket can afford an automobile as well. You are going to find, it is true, maybe, irresponsible people in all classes of life, but I don't think it is fair to put the average worker in that particular class of being irresponsible.

MR. CHAIRMAN: How is your health centre supported?

MR. HERSHEY: Yes, it is supported by contributions, by a health centre fund. The employers of our industry contribute a half of one per cent of their employees' earnings monthly into this fund.

MR. CHAIRMAN: So that works out to one cent in a year?

MR. HERSHEY: Yes, six per cent a year. As a matter of fact, our local lies, the health centre

expenditures amounted to $115,437.00.

THE CHAIRMAN: Do your employees make a similar contribution?

MR. BRESNER: No, they don't.

THE CHAIRMAN: This is entirely supported by the employers?

MR. BRESNER: Yes.

COMMISSIONER McCUTCHEON: That is still just a half of one per cent.

THE CHAIRMAN: Yes, I am sorry. I stand corrected on that.

COMMISSIONER FIRESTONE: On page 8 you say in the third paragraph:

> "We have the experience in our own medical centre where complete harmony and understanding exists between doctor and patient."

What do you mean by this, sir?

MR. BRESNER: Well, what we meant is that there is a good understanding between the doctor and the patient, and in most cases our members -- may I explain a step further?

They make an appointment. If they feel the desire or need, or want of a check-up, they make an appointment with the medical centre and maybe a day or two later they are informed of an appointment for them. Now, they have to go to a doctor. They do not select a doctor, but rather a doctor is appointed according to the chart and this doctor goes through the complete medical check-up of this individual patient. We find that in ninety-eight

THE CHAIRMAN: Do your employees make a similar contribution?

THE CHAIRMAN: This is entirely supported by the employers?

MR. BRENNAN: Yes.

COMMISSIONER McGUIGAN: That is only just a half of one per cent.

THE CHAIRMAN: Yes, I am sorry. I stand corrected on that.

COMMISSIONER FINSTROM: On page 3 you say in the third paragraph:

"We have the experience in our own medical centre where complete harmony and understanding exists between doctor and patient."

What do you mean by that, sir?

MR. BRENNAN: Well, what we meant is that there is a good understanding between the doctor and the patient, and in most cases our members -- may I explain a step further?

They make an appointment. If they feel the doctor or need, or want of a check-up, they make an appointment with the medical centre and maybe a day or two later they are informed of an appointment for them. Now, they have to get a doctor. They do not select a doctor, but rather a doctor is appointed according to the [illegible] and this doctor goes through the complete medical checkup of this individual patient. We find that in ninety-eight

per cent of the cases the member who becomes the patient, in most cases go back to the same doctor if it is necessary to continue seeing the medical centre, and we feel that the reason for that is because the doctor takes a keen interest in the welfare of the patient, not only from the point of view of what bothers or ails him, but rather his complete personal approach to the individual patient. There is a harmonious relationship between the doctor and the patient.

COMMISSIONER FIRESTONE: Well now, sir, are you suggesting that once the doctor is chosen for the patient, that then the patient has the right to go back to the same doctor?

MR. BRESNER: Yes, they have that right.

COMMISSIONER FIRESTONE: Now, sir, what is this doctor/patient relationship? Is it one that is just based on the doctor treating the patient? Is the fact that the patient does not pay him for this service directly, is that in any way affecting the doctor/patient relationship?

MR. BRESNER: No, I don't think so. It has nothing to do with because the patient does not pay the doctor. I believe that the patient, well, that is what I would say, gets a certain amount of confidence in the doctor that is treating him or her, and because of that they go back to the same doctor. Mind you, they don't have to if they don't wish.

COMMISSIONER FIRESTONE: How many doctors have you participating in that programme?

MR. BRESNER: Eight.

in most cases go back to the same doctor if it is necessary to continue seeing the medical centre, and we feel that the reason for that is because the doctor takes a keen interest in the welfare of the patient not only from the point of view of what bothers or ails him, but rather his complete personal approach to the individual patient. There is a harmonious relationship between the doctor and the patient.

are you suggesting that once the doctor is chosen for the patient, that then the patient has the right to go back to the same doctor?

what is this doctor/patient relationship? Is it one that is just based on the doctor treating the patient? Is the fact that the patient does not pay him for this service directly, is that in any way affecting the doctor/patient relationship?

MR. ROCHMAN: No, I don't think so. It has nothing to do with because the patient does not pay the doctor. I believe that the patient, well, that is what I would say, gets a certain amount of confidence in the doctor that is treating him or her, and because of that they go back to the same doctor. Mind you, they don't have to if they don't wish.

COMMISSIONER FINKESTEIN: How many doctors have you participating in that programme?

MR. ROCHMAN: Eight.

COMMISSIONER FIRESTONE: Have you asked any of the doctors whether in their opinion the patient/doctor relationship is affected adversely because the patient does not pay them? Is this answer you gave your own judgment or is it in the opinion of the doctors who participate?

MR. BRESNER: I am glad you asked that question, because I have had the opportunity to discuss some of the questions with the doctors. Mind you, unaware of the fact I was coming here, and in our conversations I have learned that it had nothing to do with the question of paying or not paying, and it was strictly the fact that there was the doctors through his conversation with the patient, or the patient with the doctor, there was a certain amount of understanding and good faith, and a good relationship between both. I don't know if you are a medical man or not ---

THE CHAIRMAN: There are two here anyway.

MR. BRESNER: I was a patient a number of times myself, and I do know that the bedside manners of a doctor is sometimes better than the pill or the prescription that he can offer to a patient, and I believe it is of the utmost importance.

COMMISSIONER FIRESTONE: Well then, based on your experience and the discussions with the doctors, anyhow, the quality of medical care or service, nor the doctor/patient relationship has suffered by the fact that the doctor is paid by the centre, and not by the patient?

CONTINUED [illegible]

any of the doctors whether to their opinion [illegible] doctor relationship is often had advisedly because the patient does not pay them? In this answer [illegible] own judgment or is it in the opinion of the doctors [illegible] particularly?

DR. [illegible]: I can [illegible] that question, because I have had the opportunity to discuss some of the questions with his doctors. Right now, [illegible] aware of his fact I was [illegible], and in our [illegible] tions I have learned what to [illegible] the question of paying or not paying, and I have [illegible] fact that there was the doctors fixed in his [illegible] with the patient. So the patient with the [illegible] was a certain amount of understanding and [illegible] a good relationship between both. I [illegible] one a medical man of [illegible]

THE CHAIRMAN: Thank you [illegible] anyway.

MR. TRUCHEN: I was a patient [illegible] of these myself, and I do know that the [illegible] of a doctor is somehow better than the [illegible] association that is [illegible] a patient, and I [illegible] it is of the utmost importance.

CHAIRMAN [illegible]: Was [illegible] based on your experience and [illegible] doctors, anyhow, the [illegible] medical [illegible] the patient/physician [illegible] fact that the [illegible] the problem, and [illegible] the patient?

MR. BRESNER: Correct.

COMMISSIONER McCUTCHEON: How are the doctors paid?

MR. BRESNER: They are paid on the time they spend.

THE CHAIRMAN: It is on a fee for service basis?

MR. BRESNER: Yes, well, they spend about three hours a day. Some of them work two or three days a week. They alternate.

COMMISSIONER FIRESTONE: They are paid so much per hour?

MR. BRESNER: Yes.

COMMISSIONER FIRESTONE: Irrespective of the number of patients they see?

MR. BRESNER: Correct. The reason is that appointments are made in advance, and if we are aware there are insufficient appointments, we call him in advance and say, not today.

COMMISSIONER BALTZAN: When there is too much work, what do you do?

MR. BRESNER: At times we get additional doctors.

COMMISSIONER BALTZAN: Do some of your people have to wait too long to get an appointment?

MR. BRESNER: No, usually the maximum period of time is about forty-eight hours.

COMMISSIONER BALTZAN: And what do you do in cases of urgent need?

MR. BRESNER: We don't handle emergencies,

COMMISSIONER MCCUTCHEON: How are the doctors paid?

MR. [illegible]: They are paid on the time they spend.

THE CHAIRMAN: It is on a per diem service basis?

[illegible]

about three hours a day. Some of them work two or three days a week. They alternate.

COMMISSIONER [illegible]: They are paid [illegible]

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MR. [illegible]: No, usually the maximum period of time is about forty-eight hours.

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MR. [illegible]: We don't handle emergency

no.

COMMISSIONER BALTZAN: Sir, I am very much interested in the element of neglect of any citizen. I heard you mention the case of some person who has called a physician, and because his fee was such and such, ten, fifteen dollars, and that was far beyond his or her ability to pay, and we are aware of things like that.

My question to you is this, have you some statistical study that would indicate the incidence of such elements of inability to pay, and therefore, not getting the services, versus the other instances of where the inability to pay has nothing to do with the fact that they still get medical care?

MR. BRESNER: In order to answer that, in all fairness, I have no statistical figures that I can provide this Commission with. As I said before, I didn't anticipate to appear before this Board, and therefore, I didn't prepare any such figures at all, but from what I can gather from the information that was given to me, the complaints were, that because of the exorbitant prices charged by the doctor to these patients, these patients would hesitate in calling a doctor again unless an emergency has arisen.

You must understand, just to finish my remarks, you must realize again if a patient, I feel that what you are driving at, is there such a case where the patient tries to bargain with a doctor?

COMMISSIONER BALTZAN: I am interested to know, and it will help us in our work here if we can have some very factual, numerical instances of this kind

COMMISSIONER BARTLETT: Can I ask one
more interpretation in one element of a request of any [illegible]
I heard you mention the case of some person who has
called a physician, and because of the fee was such as
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[illegible]
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have some very actual, numerical [illegible] in this [illegible]

versus the other where the matter of fee involved, to pay or to pay later doesn't enter into the picture of the patient getting medical attention. If you could submit statistics we would appreciate it very much.

MR. BRESNER: In order to answer that, I would be glad to see what I can prepare in this respect and I will submit it to this Board.

THE CHAIRMAN: Any further questions?

Thank you very much, Mr. Bresner. All these matters are grist to the mills as far as the Commission is concerned and will receive our consideration in due time.

MR. BRESNER: Thank you very much. I hope you will be successful in your endeavours.

THE CHAIRMAN: Is there anyone else present, either here or in the hall, Mr. Lafrance, who wishes to be heard?

THE SECRETARY: No, sir.

THE CHAIRMAN: That being the case, this concludes our hearings in Montreal, and the Commission will adjourn until we meet in Toronto on May 7th, which hearing will be proceeded by a private meeting on the evening of May 6th.

The hearing stands adjourned.

--- Whereupon the hearing adjourned to Toronto on May 7th, 1962.

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MR. [illegible]: In order to answer that, I would be glad to see what I can [illegible] in this respect, and I will submit it to this [illegible].

THE CHAIRMAN: Any further questions.

Thank you very much, Mr. [illegible]. A [illegible] these matters are quite of the utmost as far as the Commission is concerned and will receive our [illegible] attention in due time.

MR. [illegible]: Thank you very much. I hope you will be successful in your [illegible].

THE CHAIRMAN: Is there anyone else present, either here or in the hall. Mr. [illegible], who wishes to be heard?

THE STENOGRAPHER: No, sir.

THE CHAIRMAN: That being the case, this concludes our hearings in Montreal, and the Commission will adjourn until we meet in Toronto on May 7th, which hearing will be preceded by a public meeting on the evening of May 6th.

---- Whereupon the hearing adjourned to Toronto on

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

TORONTO

ONT.

VOLUME NUMBER:

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Toronto, Ontario,
on the 7th day of May, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R.N.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

MR. M. WALLACE McCUTCHEON, Q.C.

PROF. O. J. FIRESTONE

DR. DAVID M. BALTZAN

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL COUNSEL:

DR. PIERRE JOBIN

DIRECT OF RESEARCH:

PROF. BERNARD BLISHEN

COMMISSION SECRETARY:

MR. N. LAFRANCE

VOLUME 47

INDEX OF SUBMISSIONS

Toronto, Ontario,
Monday,
May 7, 1962.

/bl/hm

---On commencing at 10:00 a.m.

HON. JOHN P. ROBARTS (Prime Minister of Ontario): Mr. Chairman, members of the Commission, it is a great pleasure for me to welcome you here to Ontario and to welcome you on behalf of the Government.

We are well aware of the enormity of the task that you have set yourself. I have looked over your timetable for Ontario, and it runs to 141 submissions, and we wondered if you were being a little optimistic. But, nonetheless, I would like to offer you on behalf of the Government any and all facilities that we have.

As a Government we are not going to present a submission to you immediately. We would hope to do so a little later on; perhaps we could arrange a convenient time in the future. We are not on your list here. Nonetheless, we are very deeply interested in what you are doing, and we will make our submission in due course. But, in the meantime, I would hope that you would feel free to call upon us as a Government for any assistance that you may require, for any assistance that we can give you in the Department of Health, in the Department of Economics, which does a good deal of research, and any assistance that the Government may give to you, we would be delighted to co-operate.

I hope that you will have a pleasant and fruitful session, and, frankly, we are delighted in the interest shown in the number of submissions you are going to receive from our province. It is some indication of the importance that our people attach to

[illegible]
[illegible]
MAY [illegible], 1[illegible]

--(In [illegible])

Hon. Dr. [illegible] (Prime Minister of Ontario): Mr. Chairman, members of the Commission, it is a great pleasure for me to welcome you here to [illegible]

We are well aware of the priority of the task that you have set yourselves. I have looked over your minutes -- for Ontario, and it runs to 1[illegible] submissions, and we wondered if you were being a little optimistic. But, nevertheless, I would like to offer you on behalf of the Government any and all facilities that we have.

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I hope that you will have a pleasant and fruitful session, and, finally, we are [illegible] in the interest shown in the number of submissions you are going to receive from our province. It is a fine indication of the importance that our people attach to

this Commission and the work that you are doing and the solution that you are attempting to find for all of the people of Canada.

Welcome to Ontario, gentlemen.

THE CHAIRMAN: I want to thank you very much, Mr. Prime Minister, on behalf of my associates and those who are with us in connection with the Commission. We know that we are embarking on what will undoubtedly be the longest session, certainly the most prolonged hearings of our work, but in such pleasant surroundings in the beautiful City of Toronto, we think we can do the work and survive quite well, and starting with very nice weather.

The welcome from yourself on behalf of the Government we appreciate very much. I may say that we have already had the very best of co-operation and help from Dr. Dymond, the Minister of Health, from the other departments, and we are relying on going to the various departments for more information and help as we will require it. I think we may say, too, that it is pleasing to hear that the Province of Ontario will in due course and as and when the submission is ready make a submission on this very important topic of health under study and survey, and as soon as the Province is in a position to proceed with its submission and you get in touch with us we will make the necessary arrangement so that this will be heard.

Again, thank you very much for this welcome.

HON. MR. ROBARTS: Thank you, sir.

[illegible]

[illegible] tion and the work that you are doing is the solution that you are already [illegible]

Welcome to Ontario, gentlemen.

The Chairman: I want to thank you very much, Mr. [illegible] Minister, on behalf of my associates and those who [illegible] with us in connection with this commission. We know that we are [illegible] will undoubtedly be the longest session, considering the most protracted hearings of our work, but we [illegible] pleasant surroundings in the beautiful city of [illegible], we think we can do the work and survive quite well, and starting with very nice weather.

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Again, thank you very much for the welcome.

Mr. M. [illegible]: Mr. [illegible], sir

THE CHAIRMAN: Mr. Lafrance.

THE SECRETARY: Mr. Chairman, I would like to call forward the Ontario Medical Association, and Dr. McCreary will make a short statement and introduce the members of the group.

The main submission of the Ontario Medical Association will be known as Exhibit 238, and the appendices to the brief which were also received by the Commission will be known as Exhibit 238A.

---EXHIBIT NO. 238: Submission of the Ontario Medical Association.

---EXHIBIT NO. 238: Appendices.

SUBMISSION OF

THE ONTARIO MEDICAL ASSOCIATION

APPEARANCES: Dr. R. H. McCreary
Dr. Glenn Sawyer
Dr. R. D. Atkinson
Dr. P. Bruce-Lockhart
Dr. R.J.M. Galloway
Dr. S. N. Nathan

DR. McCREARY: Mr. Chairman, members of the Royal Commission on Health Services, as president of the Ontario Medical Association I wish to express to you as individuals our appreciation of the efforts and time that you are expending on the subject of great importance to our Association, that is a high standard of health and the personal health services of the people of the Province of Ontario.

To assist you in your enquiry we have produced a brief which is already in your hands. In this brief we have assembled considerable information. We have here today individuals who were instrumental in developing this information over the years and in committees, and we have here also those listed on the front page of our brief, each of whom will be personally introduced to you, if you require specific information from them. I would particularly introduce to you four persons our Association have decided may best develop the opinions and explain the policy of our Association. Dr. P. Bruce-Lockhart, the president elect of the Association; Dr. Glenn Sawyer, the general secretary of the Association; Dr. R. D. Atkinson, Waterloo, chairman of our Council and a member of our executive; Dr. R.J.M. Galloway, Toronto, Chairman of our Advisory Committee and

of the Royal Commission on Health Services, as President of the Ontario Medical Association I wish to express to you as individuals our appreciation of the efforts and time that you are expending in the subject of great importance to our Association, that is a high standard of health and the personal health services of the people of the Province of Ontario.

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and former treasurer and member of the executive of the Association. At this juncture and with your permission I would like to ask Mr. P. Bruce-Lockhart to introduce the presentation.

THE CHAIRMAN: Dr. Bruce-Lockhart.

DR. BRUCE-LOCKHART: Mr. Chairman and members of the Commission, The Ontario Medical Association, whom this delegation has the honour to represent, has 6,500 members. It thus constitutes about 1/3 of the total doctors in CAnada, and looks after over 6,000,000 people.

The Commission and the Ontario Medical Association have a common interest, namely, the provision of competent health services to the people of Ontario. The Commission by reason of its terms of reference - this Association through the dedication of the lives of its members to this work.

In order to assist the Commission in a better understanding of the problems in Ontario, the O. M. A. has

1. studied all previous hearings, considered carefully the questions asked by the Commissioners, and noted how frequently the same questions have been asked of all doctors.
2. With the object of answering these questions, while at the same time presenting the views of the O. M. A. on what it deems to be the vital issues, it is proposed that our presentation will be in three parts:

Firstly, I will present a broad outline of the Ontario doctor's viewpoint, in an attempt to give the Commissioners

and former treasurer and member of the executive of the Association. At this juncture and with your permission I would like to ask Mr. P. Joure-Gouraud to introduce the presentation.

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Firstly, I will present a broad outline of the Ontario doctor's viewpoint, in an attempt to give the Commission

an insight into the core of our thinking and to place our brief and arguments into perspective.

Secondly, Dr. Glenn Sawyer will summarize the comment on the recommendations in this brief, so as to give clarity and point to our priorities.

Then this delegation would like to answer any further questions deemed relevant by the Commissioners - although we believe that our presentation will have answered most of the questions asked heretofore by the Commissioners, and that they will have learned the viewpoint and policy of the O. M. A. on these vital issues.

This course of action will have the advantage of enabling the O. M. A. to make its uninterrupted presentation within the allotted time, and yet give the Commissioners the opportunity to indicate those areas on which they desire further information.

In order even to begin to understand doctors, one has first to appreciate that medical care in essence is the care of the sick individual, or the potentially sick, or the well who may become sick, but always the individual.

It is essential to understand that an individual is a human being who is unique, and different from all other human beings - different in his reaction to environment, in his reaction to illness, to drugs and to treatment, different in his reaction to management, and different in his reaction to other human beings - which must include doctors.

These differences of reaction are drummed into medical students, because bitter experience has taught the profession that unless a constant unrelenting awareness is maintained in this regard, constant mistakes will occur. The necessity for this has convinced doctors that medical care must be personal if it is to be efficient and safe. Further, that it must be personal if it is to be effective in dealing with the patient in relationship to his environment.

To place these personal services in perspective it should not be forgotten that home and office calls constitute the majority of all medical services rendered by doctors. The doctors providing personal services work long hours, and their whole life is one constant interruption. Yet few abandon it, and to understand doctors one must understand why.

The answer is not that they are, or think themselves supermen - nor even that they are just a strange breed, as some would have us believe. It is just that to date there has been an intense satisfaction in their work. This satisfaction is the result of the pleasure found in becoming involved with people, of being able to help them in their need and of caring about the results, not as cases in a slot, but as human beings.

A doctor setting out in practice is usually young, enthusiastic, and in debt. He is initially delighted and somewhat thankful to answer calls night and say. Then the financial problem improves, his

thumped into my first study, because better experience has taught the professor that unless a constant unsleeping awareness is maintained in this regard, constant mistakes will occur. The necessity for this has convinced doctors that medical care must be personal if it is to be efficient and safe. Further, that it must be personal if it is to be effective in dealing with the patient in relationship to his environment.

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A doctor setting out in practice is usually young, conscientious, and in debt. He is initially delighted and somewhat taken aback to answer calls night and day. Then the financial problem improves, his

youth and enthusiasm diminish, but he finds that he continues to accept these calls, these interruptions to his meals, his spare time, his family occasions, because by that time a call is not just another case, but young Johnny with his asthma, old Bill with another heart attack, or Mrs. Tessier with what sounds like an acute gall bladder. Herein, quite simply, lies the source of doctors' dedication and devotion to their calling.

This devotion to a patient's interests, this dedication to service, is a thing thatonly a very few lay people understand to any depth, beyond a superficial reaction typified by "that old doctor-patient relationship business". And yet if one does not understand this, how can one possibly understand our complete conviction that anything that interferes with this dedication to the individual and the job satisfaction which produces it, will ultimately -- and I would like to stress ultimately -- and quite inevitably produce a lowering of the quality of medical care. Can one buy, or compel devotion? Obviously not.

Now over the years, as spelled out in our brief, this dedication with its intense concern for the individual has produced a complex of medical services in this province which we believe is second to none; which is not static but constantly changing; and has only one criterion, namely, does it meet the need of the patient?

Living in this way the profession has always been and of course is still, acutely aware of the problems of patients; problems medical organizational

[illegible] to the enterprises [illegible], but be fitted that we continues to accept those [illegible], these interpretations [illegible]

because by that time a call is not just another case, but young lonely with its setting, old bill with another head attack, or Mrs. Teasler with her sorrows like an [illegible] ladder. Again, quite simply, the sources of [illegible] motivation and devotion to their calling.

This devotion to a patient's interests this dedication to service, is a thing shared by a very few [illegible] people under and to any degree, beyond a superficial [illegible] action typified by "[illegible] and relationship [illegible]. And yet if one does not [illegible] mission this, for the one possibly understand our complete control for that everything that interferes with this devotion to the individual and the [illegible] tion which [illegible] [illegible] and I should like to stress [illegible] and quite revolutionary [illegible] the possibility of [illegible] cases. Can one buy, or [illegible] devotion? Obviously no.

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Lastly in this [illegible] the profession has [illegible] been [illegible] of [illegible] is still, [illegible] [illegible] of the problems of patients, problems medical, [illegible]

and economic.

We must be, it is part of the fabric of our lives. We are constantly searching for and finding answers, usually initially at the individual level, and then when they have stood the test of experience, these are generally adopted. Just as we test a new drug before its general adoption in order to minimize the chance of its doing harm as well as good, so experience has taught us to shun the quick solutions to organizational problems. Our brief emphasizes the steady progress being made in solving these problems by the evolutionary process, and we are confident that given time the remainder will be solved without disturbing the essential relationship and atmosphere between doctor and patient.

However, public awareness of some of these problems - the indigent, the low income group and the uninsurables, the cost of facilities, under-doctored areas, to mention a few, has produced the urge, very natural in the inexperienced, to correct these problems immediately. Quick action in this day and age with memories of recent war time experience brings thoughts of a master plan, central control and government assistance with financing.

Political parties are, of course, not unaware that benefits to the public obtains votes. A further factor to be taken into consideration is that if governments provide monies then they feel responsible to control its expenditure.

Thus the stage is set for the present conflict of ideas between governments and the medical profession.

The economic.

We have, it is true, [illegible]
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its doing been [illegible] as good, so [illegible] [illegible] taught
us to [illegible] [illegible] solutions to [illegible] problems.
But [illegible] [illegible] the [illegible] [illegible] [illegible] in
solving these [illegible] by the [illegible] process, and
we are confident that [illegible] the [illegible] will [illegible]
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a [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
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In our brief we have stressed the theme evolution, not revolution, by stating what we have done, why, why it is good, how we are tackling the problems that remain, the needs that exist and how solutions can be evolved to meet them.

To keep this clear, we have not stated directly where we stand in this conflict of ideas, and we would be failing in our duty if we did not now take this opportunity to make quite clear where the medical profession in Ontario does stand in this regard.

First in regard to availability of medical care, we would state our opinion that in Ontario medical care is at present available to all citizens having only regard to geographic circumstances.

Secondly, our profession is convinced that very few people outside the profession understand the danger of well meaning planners seizing on a few problems in this very complex field, and producing solutions to them only to create unwittingly and quite unintentionally, a dozen new ones.

Thirdly, we are frankly afraid of any plan, or plans, with total or major government financing because history has taught us

a) that then the monies for medical care have to compete at the treasury level with the other needs of society, which means that political expediency dictates the allocation of money and not individual medical needs.

b) that costs rise way beyond estimates

[illegible]

and the easiest way to control costs is to limit facilities and services.

c) the loss of individual patient responsibility for his own care is a factor in increased costs, and further subtly alters his attitude towards his doctor. When a patient demands care instead of calling with a problem for help, then the job satisfaction of the doctor is gone.

In addition to these fears, we are flatly opposed to government ever being the sole purchaser of medical services, because quite simply we would consider this conscription. Would this situation not be vicious if the only way a man can change his employer is by leaving the country? It seems to us that it would be a new and unique position if this occurred and was acceptable, and would inevitably lead to the question of "who is next?"

In theory, a government could own an insurance plan, solve some of the economic problems of the populace and not interfere with the individual patient and his doctor. Here we would like to be careful of words. An insurance plan for medical care is a concept of people buying insurance to spread the risk. Such plans are at present available, and the problem of enabling everyone to buy insurance is discussed in our brief. However, when one talks of government insurance we believe this implies control beyond this insurance principle, because experience has taught us this. Government insurance to us means just a government run medical plan

under another name.

We are convinced that a government run plan of medical care will mean central control; that central control produces a mediocrity of care because it is geared to the masses and not to the individual and his needs. Further, because it works on an averaging principle. Frankly, we do not believe it possible to deal in norms and averages and retain complete individual patient consideration and attention.

Also, we are completely opposed to compulsion direct or indirect because one cannot have compulsion and choice. We believe that choice of doctor, choice of type of service, choice of type of prepayment mechanisms is productive of flexible selective progress geared to individual needs.

We are certain that in the long run government interference in the practice of medicine, directly or indirectly through financial control, however well intended, will affect the dedication of the doctors by diminishing their satisfaction in giving service. It will also increase the problem of finding adequate personnel. What serious student contemplating a medical career would not prefer infinitely the opportunities for freedom in service in the state to the south of us rather than a bureaucracy at home.

Mr. Chairman, we have explained as best we might our fundamental concept of medical care, we have stated our views on government intervention in medical care. We would like to complete the picture by stating that we believe that good medical care is the concern of

under another name,

We are convinced [illegible]

[illegible] the [illegible] will [illegible] [illegible]

medical control produces a [illegible] of care [illegible]

It is [illegible] to [illegible] the individual and

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Also, we are [illegible] to

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compulsion and [illegible] We believe that choice of doctor,

choice of type of service, choice of [illegible]

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government [illegible] the practice of medicine,

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well intended, will [illegible] the [illegible] of the doctors

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will also [illegible] the number of [illegible]

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career would not [illegible] the opportunities for

freedom in [illegible] the [illegible] rather

than [illegible]

Mr. Chairman, we have explained [illegible]

we might [illegible] care, we [illegible]

stated our views [illegible] intervention in medical

[illegible]

[illegible]

all of us. That to produce it the profession needs co-operation from government and voluntary agencies, that we each have our place in this field and that we have views on the proper role of government which we would like to emphasize very briefly. They are the result of a study by one of our committees and were approved by the profession in the Council of the Association 3 years ago.

The report reads:

"Our concept of the responsibility of government with regard to the health of the public is to ensure, in co-operation with, and on the advice of, the medical profession as a whole, that a high standard of medical care is available to everyone. With these thoughts in mind, we should consider the proper role of government in the field of medicine.

Central government has three advantages over any other section of the community, namely:

i) Central view and authority.

ii) The power to legislate.

iii) The provincial treasury.

It seems logical that these aspects of medicine which fundamentally require any of these things are properly the concern of government.

A. Aspects of medicine requiring

essential province-wide view:

i) Sanitation, preventive medicine, and venereal and infectious disease control.

ii) Civil defence and disaster planning.

iii) The education of the public in health and hygiene matters.

B. Aspects requiring the authority of legislation:

i) Legislative jurisdiction with respect to the licensing of doctors to practise medicine.

ii) Legislative jurisdiction over hospitals.

iii) Legislative standards for food and its handling, housing, drugs, and safety precautions in homes and factories, institutions, etc.

C. Aspects requiring assistance from the provincial treasury:

i) In situations where the individual is incapable of providing for himself because of -

a) indigency,

b) chronic or permanent mental or physical disability.

ii) In situations where a particular community would otherwise shoulder the financial load for a project beneficial

to the whole province -

a) medical education.

b) medical research.

c) facilities which are expensive or located in small number of centres, e.g. radiotherapy by Cobalt Bomb, etc. Lastly,

d) subsidizing hospital building and operating costs."

Mr. Chairman, this completes my part of the presentation and I will ask Dr. Glenn Sawyer to continue.

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DR. SAWYER: Mr. Chairman and members of the Commission, we would ask that the summary and recommendations as contained in our brief be written into this record. It is my purpose to develop briefly the reasons for the recommendations in order that you may have a better understanding of them.

SUMMARY AND RECOMMENDATIONS - INTRODUCTION

(i) The members of our Association join with other workers in the health field in welcoming you to our province. We appreciate the magnitude of your task. To assist you, we are presenting information and our Association's opinion about some of the matters detailed in your terms of reference.

(ii) We have here representatives of our Association who will amplify any matters herein recorded. Questions relating to areas where a policy has not been established will be answered in writing after due consideration has been given to them.

(iii) It should be recognized that some answers will be expressions of opinion only. Our Association is not equipped to develop statistical material related to costs, which is not immediately available to it. We regret that it was not possible for you to accede to our request to table the results of your research studies for scrutiny, interpretation and comment prior to the closing of the public hearings.

(iv) Information obtained from the research studies could play an important role in shaping your recommendations to the federal government. For that reason we believe it should be made available prior to the

Dear Sir

Mr. Chairman, Mr. Chairman and Members of the Commission, we could say that the summary and recommendations as contained in our brief be written into this record. It is our purpose to develop briefly the reasons for the recommendations in order that you may have a better understanding of them.

(i) The memorandum of our association with other workers in the health field in relating was to our province. We appreciate the magnitude of your task. To assist you, we are presenting information that our Association's opinion about some of the matters detailed in your terms of reference.

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(iv) Of certain statistics from research studies could play an important role in shaping your recommendations to the federal government. For that reason we hope it could be made available prior to the

completion of your deliberations. This would provide an equal opportunity for all interested groups and individuals to make further submissions, if it seemed appropriate to do so, in the light of the additional information.

(v) We have tried to be very candid throughout our brief in drawing attention to problem areas and indicating the consideration which our Association has been giving to them.

SUMMARY

(vi) Scientific advancements, the development of various health programs and the willingness of citizens to underwrite the costs in some areas and of government in others, have all combined to improve and expand health services in our province. In other words, it has been progress by evolution as those providing, receiving and underwriting the services reached a basis of common understanding. It is our belief that this method of improvement and expansion has provided a solid foundation on which substantial progress has been made year after year, and upon which future developments should be based. (paras. 5-7)

(vii) The role of the physician in private practice has been emphasized in the progressive development of improved health services. At the same time, it has been pointed out that his contribution has been made in co-operation with many other professional and allied groups and agencies, governmental and voluntary. (paras. 8-37)

(viii) While the basic pattern by which health services are brought to our people has not changed

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[illegible] of your activities is this we [illegible] in an equal opportunity for all interested persons [illegible] to make further suggestions, if it seems appropriate [illegible] so, in the light of the additional info [illegible]

(v) We have called to be very [illegible] throughout our brief in having attention to problem areas and indicating [illegible] assistance or advice we [illegible] have giving to [illegible]

SUMMARY

(vi) [illegible] the development of various health programs [illegible] or indicate to us [illegible] some areas [illegible] government in Alberta, have all combined [illegible] and expand health services in our province. In [illegible] it has been proposed [illegible] to these problems, providing and improving the services [illegible] basis of common problems [illegible]. It is our belief that this method of improvement and expansion [illegible] solid foundation on which [illegible] improvements [illegible] years after [illegible] upon which future developments should be based. (pages [illegible])

(vii) The role of the physician in private practice has been emphasized in the [illegible] development of improved health services. At the same time, it has been pointed out that his contribution has been made in co-operation with many other professions and allied groups and agencies, governmental and voluntary.

(viii) While the basic pattern of [illegible] should be left [illegible] to each [illegible] part of [illegible]

greatly, there have been refinements and modifications in keeping with scientific development and changes in philosophy and economics.

(ix) One of these has been the development of mechanisms whereby there is a pooling of manpower, e.g., partnerships, groups and clinics, as a method of practice, and the organization of specialized units to cope with complex clinical problems in some hospitals, e.g., respiratory and cardiovascular units. (paras. 38-45)

(x) An indication of the scope of our Association's continuing interest in health services has been outlined. We have attached as appendices current reports of some Committees and Sections to indicate the depth and comprehensiveness of study undertaken in attempting to find solutions for problems in different areas.

(xi) We have emphasized the importance of the work accomplished by many committees of our Association in enhancing the quality of medical care. Acknowledgement has been made of the co-operation and assistance received from departments of the provincial government and voluntary agencies in this endeavour. (paras. 82-100)

(xii) The importance of sufficient personnel in the health field has been emphasized. Attention has been drawn to the small percentage of students, (7.6 percent of those entering secondary schools,) who acquire the qualifications necessary for training in medical and para-medical aspects of health services. (paras. 48-51 and 150-174)

(xiii) Some of the reasons for not

[illegible]

[illegible] have been [illegible] and [illegible] in teaching with science [illegible] are changes in philosophy and economics.

(iv) [illegible]

[illegible] etc., [illegible], [illegible] are other [illegible] of practice, [illegible] modification of [illegible] to cope with complex [illegible] modern in home [illegible], etc., respiratory and cardiovascular [illegible]. (Dent: [illegible])

(x) [illegible] introduction of the [illegible] of our [illegible] curriculum. We have included as a [illegible] [illegible] amount of some [illegible] and [illegible] to [illegible] the [illegible] and [illegible] of study [illegible] in [illegible] [illegible] to find solutions for problems [illegible].

(xi) We have emphasized the [illegible] of our work accomplished by many [illegible] [illegible] association in [illegible] the quality of [illegible] [illegible] development has been one of the [illegible] [illegible] [illegible]. The [illegible] of the provincial government and [illegible] agencies in this are [illegible]. (Dent, [illegible])

(xii) The importance of [illegible] [illegible] in the health [illegible] has been [illegible]. [illegible] [illegible] has been [illegible] to the small percentage of students [illegible]

[illegible] qualifications necessary for training in medical and [illegible] - a [illegible] of health services. (Dent, [illegible])

(xiii) [illegible] of the [illegible] [illegible]

choosing medical or para-medical careers have been set down. The necessity for longer range planning for the personnel requirements of the future and the facilities and staff required for their education have been stressed. (paras. 52-58)

(xiv) We have advocated that the remuneration of para-medical workers be reviewed by their professional associations in collaboration with the Ontario Hospital Association, the Ontario Hospital Services Commission and our Association. (para. 174)

(xv) The shortage of physicians in the public medical services due to inadequate salary levels has been pointed out. It has been suggested that correction of this situation would improve these health services and reduce the loss of these physicians through emigration. (para. 59)

(xvi) We have indicated areas which require further study, e.g., undergraduate education of students, student subsidy, post-graduate training and continuing education of general practitioners and specialists, and the distribution of physicians. (paras. 61-72 and 107-117)

(xvii) We have indicated our desire to have the assistance of the universities and the Department of Health in continuing a study of medical needs of smaller communities. Our Association has started a special study to seek information in this important area. (para. 73)

(xviii) The change in the management of patients with mental illness has been stressed and the

choosing medical or [illegible] have been cut down. The necessary [illegible] planning for the personnel requirements of the future in the medicine and staff required for their [illegible] have been stressed.

(xiv) The [illegible] of the [illegible] rehabilitation of [illegible] workers is [illegible] by their professional associations in collaboration with the Ontario Hospital Association, the Ontario Hospital Services Commission and our [illegible].

(xv) The shortage of [illegible] in the public medical services due to inadequate salary levels has been pointed out. It has been [illegible] that [illegible] of this situation would improve these [illegible].

(xvi) [illegible] indicated areas which require further study, e.g., undergraduate education of nurses, student [illegible], post-graduate training and continuing education of general practitioners and [illegible].

[illegible]

[illegible] have indicated our desire to [illegible] the activities of the universities and the government in [illegible] in continuing a study of medical [illegible] and [illegible] of associations has [illegible] [illegible].

(xviii) The change in the [illegible] of [illegible] in which medical [illegible] has been [illegible] and [illegible]

developments necessary in this field to remove all disparity in treatment between mental and physical illness has been outlined. (paras. 175-178)

(xix) Information gained from a one-year survey of handicapped children, conducted by our Association, has been filed. The need for, and our interest in, identification and registration of handicapped children has been stated. The need for a council made up of representatives from health, education and welfare, for the purpose of co-ordinating agencies and programs and integrating services, has been emphasized. (paras. 91-95)

(xx) Our approval of the fluoridation of public water supplies; the need for health units in some areas where they do not now exist; and the importance of clean water and sewage disposal have been outlined by our Committee on Public Health. (Appendix #19)

(xxi) The shortage of facilities, including hospital beds and domiciliary accommodation, has been noted and recommendations made to assist in correcting this situation. (paras. 118-128)

(xxii) We have suggested that the problem of transporting patients for continuing treatment should be the subject of further study by the voluntary agencies. (paras. 135-141)

(xxiii) We have stated our intention of calling a conference on ambulance services and have suggested participation by the Ontario Hospital Association, the Ambulance Operators' Association and the Ontario Hospital Services Commission. (para. 137)

[illegible]

[illegible] disparity in the [illegible] and [illegible] has been outlined. [illegible]

(xix) [illegible] a comprehensive survey of handicapped children, conducted by our Association, has been [illegible]. The need for, and our interest in, [illegible] and rehabilitation of handicapped children has been stated. The need for a council made up of representatives from health, education and welfare, for the purpose of co-ordinating [illegible] and programs and integrating services, has been [illegible]

[illegible]

of public water supplies, the need for [illegible] in some areas where they do not now exist, and the inadequate [illegible] ocean water and sewage disposal have been outlined by our committee on [illegible]. (Appendix [illegible])

(xx) The shortage of [illegible]

[illegible]

[illegible] (Page, [illegible])

[illegible] We have suggested that the [illegible] or transportation [illegible] [illegible] should be the subject [illegible] study by the [illegible] [illegible] (Page [illegible])

[illegible] We have stressed our [illegible] building [illegible] [illegible] are [illegible] [illegible] by the [illegible] [illegible], the [illegible] [illegible] Association and the [illegible] [illegible] [illegible]. (Page [illegible])

(xxiv) The problem areas in rehabilitation as delineated by those attending the Association's second conference, held in March 1962, are outlined. The need for the appointment of a provincial co-ordinator and for greater community interest in this field have been emphasized. (paras. 33-37)

(xxv) We have described home care plans in our province and indicated the need for further study and evaluation. (paras. 129-134)

(xxvi) We have emphasized that continuing improvement in health services requires an on-going program of fundamental and clinical research. (paras. 241-245)

(xxvii) Our Association's opinion about the proper role of government in the field of medicine, has been outlined. (para. 143)

(xxviii) The history and development of medical services insurance in our province has been reviewed. The rapid progress made and the advantages of a system of competing multiple carriers have been stressed. The approaches and proposals to assist in making available insurance mechanisms to those not eligible at present have been outlined. The contribution of the medically sponsored non-profit service plans has been emphasized.

(xxix) We have stated our resultant opinion that all these carriers should be encouraged to continue. (paras. 179-240)

(xxx) We have indicated the willingness of the profession to provide care to all citizens regardless of economic status. We feel that government is

[illegible]

[illegible] sector endeavours held in March 1962, are outlined. The need for the development of a provincial co-ordinating and for greater community interest in this field has been emphasized. (pages 34-37)

In our province we [illegible] the need for further study and evaluation. (pages 37-40)

(xxvi) We have approached our continuing improvement in health services requires an expansion program of fundamental and clinical research. (pages [illegible])

(xxvii) Our Association's opinion about the proper role of government in the field of medicine, has been outlined. (page 41)

(xxviii) The history and development of medical services insurance in our province has been reviewed. The social insurance case and the advantages of a system of compulsory [illegible] contributions have been stressed. The opposition and problems to assist in making available insurance coverage to those not able at present have been outlined. The contribution of the medically sponsored non-profit service plans has been emphasized.

(xxix) We have stated our belief that all these matters should be approached in [illegible]

(xxx) We have indicated our willingness to the production to provide care to all citizens regardless of economic status. We have that government in

fulfilling its proper role when it assists those unable to provide for themselves because of economic circumstances. The profession has co-operated in caring for these people by helping to underwrite the cost of their medical care through the Medical Welfare Plan.

(xxxi) For reasons described in this brief, we believe the Medical Welfare Plan should be expanded to include those who can support themselves but who cannot afford to either pay for or prepay the cost of their medical care. (paras. 198-201)

(xxxii) In this situation there would not appear to be any reason for government to destroy the existing insurance industry in this field by going beyond its normal function of providing health services insurance for those unable to provide it for themselves.

(xxxiii) Moreover, we are aware that the financial resources of government are not unlimited. Thus it would seem wise and prudent to direct the remainder of the available funds toward health services which individuals or communities cannot provide for themselves.

(xxxiv) We have suggested that, in the use of these available funds, priority be given to improvements in the management of mental illness, the provision of adequate health services facilities and the recruitment and education of sufficient personnel for all health services. (paras. 246-248)

THE ONTARIO MEDICAL ASSOCIATION RECOMMENDS:

1) THAT the Department of Education, the universities and educational associations be commended

[illegible] fulfilling its proper role [illegible] pay, to provide for themselves [illegible]

these people by belonging to [illegible] of their medical care through the Federal [illegible] Plan.

[illegible] ment, we believe the Federal [illegible] Plan [illegible] be expanded to include those who can support themselves but who cannot afford to either pay for or [illegible] the cost of their medical care. (Para. [illegible])

xxxii In this situation there would not appear to be any reason for government to [illegible] the existing insurance industry in this [illegible] beyond its normal function of providing health services [illegible] for those unable to provide [illegible] for themselves.

xxxiii However, we [illegible] the financial resources of government are not unlimited, thus it would seem wise and prudent to direct the considerable [illegible] funds [illegible] individuals [illegible] cannot provide for themselves.

(xxxiv) We have suggested that, in the use of these [illegible], priority be given to improvements in the treatment of mental illness, the provision of adequate health services facilities and the recruitment and education of sufficient personnel for all health

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(1) [illegible] Department of [illegible]

for their concern about the small percentage of students entering secondary schools who complete Grade XIII and we recommend that they intensify their efforts to determine and correct the factors responsible for this situation.

2) THAT government provide funds for facilities and staff, through institutions teaching health personnel, so that sufficient may be educated to meet present and future needs.

3) THAT the financial requirements of students, training in the health field, be studied further by the teaching institutions, professional associations and government.

4) THAT the Royal Commission on Health Services endorse the principle that all beds in any hospital operating under the Public Hospitals Act, other than those required for teaching units, should be available to every qualified physician in the hospital's area, within the limits of his individual competence.

5) THAT the autonomy of hospitals be preserved.

6) THAT the Royal Commission on Health Services endorse the recommendation, made previously by the Canadian Medical Association, whereby expenses incurred by physicians in attending post-graduate courses would be deductible for income tax purposes.

7) THAT the inadequate salary levels now in effect for physicians employed in the public medical services be corrected, thereby reducing the loss of physicians from these services, the province, and Canada.

[illegible]

[illegible] secondary education [illegible]
become so that they interest [illegible] to [illegible]
and correct the [illegible] [illegible] this situation

facilities and staff, [illegible] [illegible] [illegible]

most pressing and [illegible] needs.

students, remaining in the health field, be studied [illegible]
by the teaching institutions, professional associations [illegible]

[illegible] the Royal Commission on health
services recommend the [illegible] that all health in any
hospital operating under the public hospitals [illegible]
than those requiring [illegible] units, should be
available to every qualified physician in the hospital [illegible]
area, within the limits of the individual community [illegible]
[illegible] the economy of hospitals [illegible]
preserved.

[illegible] the Royal Commission on health
[illegible] emphasis [illegible] prevention, more preferably by
[illegible]
[illegible] by physicians in [illegible] postgraduate courses
should be [illegible] in the [illegible]

[illegible] the [illegible] salary levels
in [illegible] employed in the [illegible]
[illegible] in [illegible], thereby reducing the loss
of physicians from these [illegible] the provinces, [illegible]
[illegible]

8) THAT the determination of the need for hospital beds and domiciliary accommodation be a joint endeavour of the Ontario Hospital Association, the Ontario Hospital Services Commission and our Association. Further, that once need has been established, the cost be assessed against the federal, provincial and municipal governments according to a formula agreed upon by those governments.

9) THAT the amount and ratio of contributions of the federal, provincial and municipal governments to the capital costs of hospital construction be reviewed.

10) THAT the cost of hospital construction assessed against a municipality should reflect the use made of the hospital by the residents of that municipality.

11) THAT mental illness be recognized as our most serious health problem; that there be a change in approach to the management of the mentally ill to bring it into line with that of other illnesses, with particular reference to out-patient services, hospitalization, rehabilitation and insurance coverage; and that psychiatric research be expanded.

12) THAT a provincial co-ordinator on rehabilitation be appointed and given authority to direct government effort in this field; and that communities be encouraged to initiate local programs including the development of sheltered employment and workshop facilities.

13) THAT there be an accelerated program of medical research supported by funds designated for that

8 [illegible]

8) [illegible] the [illegible] of the [illegible] the requires beds and [illegible] accommodation [illegible] [illegible] of the [illegible] [illegible], the [illegible] Hospital Services Commission [illegible] [illegible], that once need has been established, the cost be borne [illegible] the Federal, provincial and municipal governments [illegible] to a [illegible] [illegible] [illegible] [illegible] [illegible].

9) THAT the amount and ratio of contributions of the federal, provincial and municipal governments to the capital costs of hospital construction be reviewed.

10) THAT the cost of hospital [illegible] [illegible] tion already [illegible] a multiple [illegible] [illegible] use made of the hospital by the [illegible] [illegible] [illegible] priority.

11) THAT mental illness be recognized as our most serious health problem [illegible] there be a change in approach to the management of the mentally ill to bring it into line with that of other illnesses, with [illegible] [illegible] reference to out-patient services, "asylum" [illegible] rehabilitation and [illegible] coverage, and that systematic research be expanded.

12) THAT a provincial coordination [illegible] rehabilitation be [illegible] and given authority to [illegible] governments [illegible] to this field; and that [illegible] be encouraged to [illegible] long programs [illegible] development of [illegible] environment [illegible] [illegible] the [illegible].

13) THAT there be an [illegible] program [illegible] of [illegible] [illegible] by [illegible] [illegible] [illegible]

purpose and administered by an agency such as the Medical Research Council.

14) THAT priority be given to suggested improvements in the management of mental illness, the provision of health services facilities, and the recruitment and education of sufficient health services personnel.

15) THAT the efforts of the insuring agencies to provide satisfactory plans, through such methods as individual, group and community enrolment; through the right to retain coverage on retirement; and through the pooling of costs of high risk individuals, be commended; and

We recommend continuing and intensified efforts by these agencies to achieve the goal of universal availability of such plans; and

We recommend that there be added to the rolls of the Medical Welfare Plan, financed by the Department of Public Welfare and administered by our Association, those citizens, to be determined by mutual agreement, who are unable to purchase medical services insurance because of financial inability to do so; and

THAT those members of the community, who are financially able to do so, retain the responsibility of paying for or prepaying the cost of their medical services; retain the freedom of choosing whether to prepay it or not; and retain the freedom of choice of plan to meet their needs.

You will appreciate that many of the problems confronting you as Commissioners have formed the basis of continuing study by committees and sections of

our Association. The appendices, to which we would direct your attention, are the result of such studies over the past few years. The suggestions contained in them relate to improvement in various aspects of health services and are worthy of your consideration.

I would like to discuss five broad areas of recommendations. At the conclusion of my remarks I would be happy to direct any questions you might have to members of our Association who are here to assist you.

The first area is PERSONNEL.

There is an old saying that an army marches on its stomach. Health services march on personnel and it is as difficult to develop adequate health services without personnel as it is to make the proverbial bricks without straw.

From reading briefs presented to you previously, it is apparent that the shortage of personnel is not unique in our province. Each area has reasons why this is so. In Ontario we have a rapidly expanding population demanding more and more health services. Added to that has been rapid advances in medical science making it possible to give a wider area of increasingly complex services.

In contrast to what is happening in industry, where automation is creating a lessening demand for personnel, the complexity of health services requires a constant increase both in the number and in their qualification. The difference, of course, is because health services are personal services, whether they are rendered by a physician, a nurse, or a physiotherapist.

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In contrast to that is happening in industry, where automation is creating a lessening demand for personnel, the complexity of health care requires a constant increase even in the number and in [illegible] qualification. [illegible], of course, is because health services are personal services, whether they are [illegible] by a [illegible] nurse, a doctor, or a physiotherapist.

The physician is dependent upon the other members of the health team. If there is a shortage of personnel in one category, it can affect the quantity and quality of available health services. We find this, for example, in our hospitals, where wards are sometimes closed because of the shortages of nurses.

The branch societies and sections of our Association have indicated in their submissions shortages in many categories of health service personnel.

The first question which arises is the number of students available who have the qualifications required for acceptance for training in the health field. An examination of the students who entered high school in Ontario in 1955 reveals that at the end of 1960 only 4,718 (7.6%) had the necessary qualifications. The various health professions had to compete with all other groups requiring these qualifications from this small percentage.

We are aware that those interested in education are concerned about this situation. While commending them for their concern, we have recommended intensified efforts to delineate and correct the factors responsible.

With the relatively small number available it becomes a matter of ability to attract students in the health field, who have the qualities of heart and mind required to render dedicated personal health services. It is our opinion that while remuneration is important, the test in the final analysis will be ability to render professional services in a manner which will produce the

[illegible] [illegible] [illegible] [illegible] other [illegible] of the health team. [illegible] [illegible] [illegible] of personnel in one [illegible], [illegible] [illegible] and quality of medical [illegible] [illegible] [illegible] [illegible], for example, in our [illegible] where [illegible] [illegible] [illegible] [illegible] [illegible].

[illegible] [illegible] [illegible] of our Association have indicated in their submissions [illegible].

The first question [illegible] [illegible] is the number of students [illegible] [illegible] [illegible] required for [illegible] [illegible] training [illegible] [illegible]. In examination [illegible] [illegible] who entered [illegible] school in Ontario [illegible] that of the [illegible] [illegible] [illegible] the necessary qualifications [illegible] numerous [illegible] [illegible] [illegible] groups recruiting those qualifications from [illegible] [illegible].

[illegible] [illegible] that [illegible] [illegible] increase in addition are [illegible] [illegible] [illegible] committee that, [illegible], we [illegible] recommended [illegible] [illegible] to [illegible] and [illegible] the [illegible] responsibilities.

[illegible] [illegible] [illegible] it becomes a matter of [illegible] to attract [illegible] [illegible] the health field, [illegible] have the qualities of [illegible] and [illegible] [illegible] [illegible]. [illegible] [illegible] is important, [illegible] [illegible] [illegible]

satisfaction on which professional services are dependent. A survey of 597 Grade XIII students, attached to this brief as an appendix, would substantiate that view.

Having trained health workers, the next problem is to keep them. The Section on Salaried Physicians has drawn to our attention the situation in the public medical services, staffed by salaried physicians, of our province. Here the loss of physicians through emigration causes concern about the quality of these services. The loss is attributed to the low salaries paid in Ontario as compared to those avaiable in private practice and also in salaried positions outside the public service. It is pointed out that both the salaries available and their relationship to earning in private practice are factors causing emigration to the United States.

There is a loss of para-medical personnel through emigration and this is to be regretted. A more serious loss, however, is from marriage. By tradition, the vast majority of workers in the para-medical field have been female. Attempts to attract men into this work have not been very successful to date. This is difficult to understand from a physiological point of view. The answer, again, has been given as inadequate salaries both during and after training, so that a man with family responsibilities seeks other employment.

We have indicated in our brief the need for continued study of the financial support required of trainees in all areas of the health field.

Our recommendations in this area are:

THAT the study now being made by our educationalists be intensified to determine and correct the factors responsible for the small percentage of students graduating from Grade XIII with the qualifications required for entrance into training in the health field.

THAT the financial requirements of students in training be reviewed.

THAT salary levels be made such as to retain our health workers and attract more male workers into the para-medical work, and

THAT provision be made for necessary staff and facilities to meet future needs for personnel in the health field.

FACILITIES

The mention of facilities brings us to the next area. We did not expand on the need for facilities for the training of physicians and all other health workers because the needs in this area will undoubtedly be brought forward by the universities and others.

We do want to say something about the facilities required for the care and treatment of the sick. The first of these is hospitals; acute, convalescent and chronic. While the picture generally in the province has improved, there are areas where there has been a particularly rapid growth of population where the situation is very poor indeed. Metropolitan Toronto is a good

example. Here there are 3.9 beds per thousand as compared to the provincial average of 5. Here, too, the municipal government has refused to participate in the costs of hospital construction.

A review of contributions for hospital construction shows that the federal and provincial governments combined have contributed one-half as much as is left as the responsibility of the local municipality and the citizens. Hence, when the municipal government refuses to participate, the matter of hospital construction places an unbearable burden on the backs of even the most willing citizens.

We have suggested that the contribution made by the two senior levels of government be reviewed and a formula worked out with the municipalities. Then when need for a hospital has been determined by the Ontario Hospital Services Commission in co-operation with the Ontario Hospital Association and our Association, the funds would be available. This would give the O.H.S.C. the fiscal autonomy in this area which we feel is required to produce adequate facilities. As one man remarked:

> "Children are provided a seat in school and a gymnasium in school to play in but if they get sick there may not be a hospital bed available to lie in."

The requirement for hospital beds can be lessened if there is sufficient domiciliary accommodation, i.e., nursing homes and homes for the aged, where those requiring care, but not continuing medical and nursing care, may be transferred. While the Department

of Public Welfare is making determined efforts to meet the need in this area, it would seem reasonable that there should be the closest liaison between the O.H.S.C., which is responsible for hospitals and the Department of Public Welfare, responsible for domiciliary accommodation.

There are special needs for facilities.

One of these is for the treatment of mental illness as outlined in the submission of the Section on Psychiatry. The requirement is for both small psychiatric hospitals beside general hospitals, and also psychiatric units within general hospitals.

A second conference on rehabilitation recently, emphasized again the need for community participation in the provision of workshop facilities and sheltered employment.

Similar recommendations have been made by our Committee on Child Welfare as a result of a one-year survey of the needs of the handicapped children.

In all of these areas facilities for research are a continuing requirement.

In the area of facilities, then, we would direct your attention to the need for:

Facilities for training health workers.

Hospital facilities - acute, convalescent, chronic.

Domiciliary accommodation - nursing homes, homes for the aged.

Special facilities for:

The treatment of mental illness,

[illegible]

of public welfare is [illegible] essentially [illegible] to the
one used in this [illegible], it [illegible] reasonable that
there could be the [illegible] between the [illegible]
which is responsible for [illegible] the [illegible] of
public welfare, [illegible] [illegible] accommodation.

[illegible] the treatment of
mental illness as [illegible] in the [illegible] of the
section on [illegible]. The requirement is for both social
[illegible] [illegible] [illegible] [illegible] [illegible].

A second conference on [illegible]
recently, [illegible] the need for [illegible] participation in the [illegible] of workshop facilities and
shelters [illegible].

[illegible] [illegible] [illegible] have been made
by our Committee on [illegible] will be [illegible]
very number of the [illegible] of the handicapped [illegible].

In all of these [illegible] [illegible]
[illegible] [illegible] [illegible].

In the [illegible] of facilities, [illegible], we
would direct your attention to the need [illegible]
[illegible] from [illegible] [illegible]

[illegible] [illegible] [illegible] - [illegible],
[illegible], [illegible].

[illegible] [illegible] - [illegible]
[illegible], [illegible] for the [illegible].

[illegible]

The [illegible] of [illegible] [illegible].

for rehabilitation,

the care of the handicapped children, and

research.

UTILIZATION OF PERSONNEL AND FACILITIES IN THE IMPROVEMENT OF HEALTH SERVICES

There are areas as indicated in the brief, where continuing study is required in the utilization of personnel and facilities.

We have stated the opinion of the Association that the needs of university hospital teaching units must be met in order to assure a high quality of medical graduate. These units must be under the control of the university staff. Other than that, it is our opinion that hospital beds coming under the Public Hospitals Act should be available to doctors of the community within their competence to use them.

In speaking of hospitals, we have expressed our concern lest the autonomy of hospitals be lost because of having only one purchaser of basic hospital services.

The continuing work of our committees and sections has demonstrated areas for improvement in the use of personnel and facilities.

There is need for a change in the management of mental illness to bring it into line with the management of physical illness. This will require more community interest in hospital construction and management and more participation in patient care by the doctors of the community.

In rehabilitation there is need for a

provincial co-ordinator to integrate the interest of government departments in this area.

Handicapped children should be registered and our Association is considering undertaking this task. There is need for a council composed of representatives of health, education and welfare for the purpose of co-ordinating agencies and programs and integrating services.

Public health measures requiring attention are fluoridation of communal water supplies, the correction of air and water pollution and the establishment of public health units in areas of the province now without them.

The benefits of occupational health services to the working population in maintaining and improving health are worthy of mention.

Consideration of medical aspects of traffic accidents has focused attention on the need for improved ambulance services; the need for driver education; the value of seat belts; and the problems created by the "drinking driver."

As indicated in the brief, we are reviewing the adequacy of medical services starting with the needs of smaller communities.

We have, thus, indicated areas where continuing study and co-operation will result in a use of personnel and facilities to improve further the health services available for our people.

RESEARCH

The need for an on-going program of

[illegible]

research is a constantly recurring theme by all those interested in any aspect of health services.

It is our opinion that it is a proper function of government to supplement research funds provided by other interested bodies and that these research funds should be administered in the main by a body such as the Medical Research Council.

Grants to research workers should be such as to relieve their dependence on teaching or practice as a means of financial support.

The other important consideration is that grants for research should be for sufficient length of time to avoid frustration and waste and at the same time attract and keep trained research workers in our country.

We commend the needs in this area for your serious consideration.

PREPAYMENT MECHANISMS

We have been impressed by the rapid expansion of prepayment mechanisms in our province. In 1950, 26% had surgical coverage and 14% medical. Ten years later these figures had risen to 63% and 59%, respectively.

We have commended our insuring agencies for their efforts to continue further expansion by such methods as individual, group and community enrolment and the pooling of high cost individuals.

The coverage of indigents through the Medical Welfare Plan has been explained. Our recommendation is that those falling into the marginal income group

should be added to the Plan. They are able to supply their other essential needs but haven't funds to prepay or pay for their medical care and, therefore, may be reluctant to seek it.

We are confident of reaching the goal of universal availability of plans which will meet the needs of our people within the foreseeable future.

That being so, there would not appear to be any reason for recommendations in this field that government go beyond its normal function of assisting those unable to assist themselves.

The funds which any government can raise through the various forms of taxation are limited. Therefore the amount of money available from government for health services will always be limited.

It becomes a question then, of where these limited funds can be used to promote the greatest improvement in health services.

We have given this question the serious consideration it deserves and have stated our opinion that priority should be given to the improvement in the management of mental illness as this is our most serious health problem; and to the provision of adequate health services facilities and the recruitment and education of sufficient personnel for all health services.

M/hm

Mr. Chairman, that completes my remarks and we would indeed by happy to receive any questions which you or the members of your Commission may have.

THE CHAIRMAN: Thank you, Dr. Sawyer. I think I might be permitted to observe that the submission which we have received, the written submission which we have received from the Ontario Medical Association is a document that contains a great deal of factual information as well as your recommendations and opinions which have been extended and elaborated here this morning by Dr. Bruce-Lockhart and yourself. For the moment I must say how grateful we are for the contents of the blue section of the book because there is a great deal of information which will be of much value to our research staff and to the Commission as we proceed with our work and go forward towards coming to some conclusions. Actually the summation this morning, the contents of your brief and the factual information in the blue section does give, in a great measure, much of the information that we have sought elsewhere. There are, however, some areas in which we may, members of the Commission may wish further information or explanation.

We recognize that in some instances the information will be already in the book but we may find it easier for you to say it over again rather than to look for it. If you will bear with us in that regard.

Now, just dealing with your problem in

"Mr. Chairman, that concludes my remarks and we would indeed be happy to receive any questions which you or the members of your Commission may have.

I think I might be permitted to observe that the submission which we have received, the written submission we have received from the Ontario Medical Association is a document that contains a great deal of factual information as well as your recommendations and opinions, which have been examined here this morning by Mr. Arrowsmith and yourself. For the moment I must say how grateful we are for the contents of the first section of the book because there is a great deal of information which will be of such value to our association staff and to the Commission as we proceed with our work and go to meet witnesses coming to some conclusions. Totally, the submission this morning, the contents of your brief and the factual information in the first section does give, in a great measure, much of the information that we have sought elsewhere. There are, however, some areas in which we may, members of the Commission may wish further information or elaboration.

I am reminded that in some instances the information was already in the book but we may find it easier for you to pay it over again rather than to look for it. If you will bear with us in that

"Now, just dealing with your problem in

Ontario in a very general way, Dr. Sawyer, you began your summation this morning dealing with the matter of personnel and you suggest that there are shortages. Now, shortages naturally are relative things, relative to population needs and so forth. On the basis that the ratio of doctors to one thousand population or whatever figure you take in Ontario, it is one of the highest figures that we hear of. You accept that, your ratio in Ontario being what?

DR. SAWYER: Well, it is in the brief.

THE CHAIRMAN: I know it is in the book. By the way, if you would care to sit down and have better access to this information you are quite at liberty to do so.

You say you represent 6,500, in round figures, of the medical profession in Ontario and that is 6,500 out of 8,200 doctors?

DR. SAWYER: That is correct, sir.

THE CHAIRMAN: And of that number is it a fact that your ratio per population is the highest in Canada?

DR. BRUCE-LOCKHART: Our ratio is one doctor for every one hundred sixty-four population.

THE CHAIRMAN: Is there another area better served?

DR. SAWYER: I do not know of one.

THE CHAIRMAN: So what do you say about this question of shortages? In fact, is it serious or what are you talking about when you are talking about

[illegible]

[illegible] in a very general way. In answer, you [illegible] your admiration this morning dealing with the matter of personnel and you suggest that there are [illegible] [illegible], shortages actually are [illegible] things, relative to population needs and so [illegible]. On the [illegible] that [illegible] to come [illegible] particular [illegible] [illegible] you face in Canada. It is one of the [illegible] [illegible] we need [illegible] to answer that, you [illegible] in [illegible] to [illegible] why?

Mr. SANDER: Well, it is in the [illegible].

The CHAIRMAN: I know it is in the [illegible] by the way. If you would care to [illegible] a better access to this information you are [illegible] [illegible] to do so.

[illegible] new you [illegible], in round [illegible] of the [illegible] [illegible] and then [illegible] [illegible]?

Mr. SANDER: That is correct, sir.

Mr. CHAMBERS: And of that number is [illegible] per population is the highest [illegible]?

Mr. SANDER: The ratio is one [illegible] for every hundred thousand population.

Mr. CHAMBERS: In there another [illegible] [illegible]?

Mr. SANDER: I do not know of one.

Mr. CHAMBERS: Do then we [illegible] [illegible] this [illegible] in [illegible]? In fact, is it [illegible] [illegible] what are we [illegible] when you are [illegible] [illegible]

shortages when you have the best situation in Canada?

DR. SAWYER: Well, I think you have to remember that there are only a certain number of medical schools in Canada and we have some responsibility for training of personnel for provinces which do not have those facilities.

THE CHAIRMAN: If you will permit me, I do not think that is what we are talking about; I am talking about the actual number practising in Ontario today.

DR. SAWYER: You are speaking only of physicians?

THE CHAIRMAN: Yes. Do you say that there is an actual shortage and what is that shortage?

DR. BRUCE-LOCKHART: I think we are possibly talking along slightly different lines. I think what we would say is that numerically we can argue we have enough doctors but there are certain ones, undoubtedly mental health, where there is a shortage now. In other words, you may have an overall average adequate number but there is another factor involved in distribution. For instance, in mental health we are something like 50% short of the adequate number of doctors we ought to have to give adequate mental health service. When we are speaking of shortages it is the area we are talking about, specific shortages in certain areas. To say we are short in the whole community would be nonsense because the average is high but as I pointed out this morning, averages are not everything.

Another problem we have is that in

shortages which you have the best situation in mind.

Dr. SAWYER: Well, I think you have to remember that there are only a certain number of medical schools in Canada and we have some responsibility for training of personnel for provinces which do not have those facilities.

The CHAIRMAN: If you will permit me, I do not think that is what we are talking about, I think, about the actual number practising in Canada today.

Dr. SAWYER: You are speaking only of physicians?

The CHAIRMAN: Yes. Do you say that there is an actual shortage and what is that shortage?

Dr. [illegible]: I think we are really talking about slightly different things. I think what we would say is that in relation we can argue we have enough doctors but there are certain areas, and certainly mental health, where there is a shortage now. In other words, you may have an overall average adequate number but there is another factor involved in distribution. For instance, in mental health we are starting just with some of the adequate number of doctors we expect to have to give adequate mental health services. When we are speaking of shortages in the area we are talking about, specific shortages in certain areas. To say we are short in the whole country would be misleading because the average is high but in certain areas it is not so. Averages are not everything.

Another problem we have is that in

Canada some 25% of these doctors were doctors trained overseas and we do not know how much one can rely on a continuing immigration; maybe we can but we have to face the problem of emigration and this makes it difficult. We are in the unhappy position in Canada altogether that we are not producing enough doctors of our own for our own needs and having to rely on a fairly chancy bit of importing. We have to relate that to our export. I think that is a fair answer.

DR. GALLOWAY: I would refer you to page 239 in the blue section where we summarize the present and future requirements of the branch societies through districts.

THE CHAIRMAN: Page 239?

DR. GALLOWAY: Yes, and the appendices.

THE CHAIRMAN: That is your position situation. Now, what about nurses, you also mention those?

DR. GALLOWAY: On page 240.

THE CHAIRMAN: Is it not a fact again that, apart from British Columbia, you have the highest ratio of nurses to population in Canada?

DR. BRUCE-LOCKHART: Again we are up against a problem. These are statistics and statistics are not always as valid as they look. In my own area, for instance, I am sure we have a very large number of nurses, but this includes everyone who is registered and a lot of them are married and only do part time work or do not work and we still have a chronic shortage in fact of nurses in our hospitals. We find it difficult

[illegible]

[illegible] 4-5

[illegible] some [illegible] doctors [illegible] overseas and we do not know how many one can rely on a continuing immigration; [illegible] we can but we have to face the problem of [illegible] and this means [illegible] this country. We are in the unique position in Canada [illegible] we are not producing enough doctors of our own for our own needs and having to rely on a [illegible] country but of course [illegible] to our account. I think that is a [illegible] answer.

DR. [illegible]: I would refer you to page 150 in the blue section where we summarize the present and future requirements of the [illegible] districts.

[illegible] (CALGARY): Page 150?

DR. [illegible]: Yes, and the [illegible]

MR. [illegible]: That is very [illegible] situation. Now, what about nurses, you also mention [illegible]

DR. [illegible]: On page 248

MR. CHAIRMAN: Is it not a fact again that, apart from [illegible] Columbia, you have one [illegible] ratio of nurses to population in Canada?

DR. [illegible]: Again, we are [illegible] that a problem. There are [illegible] are not [illegible] in my own area, [illegible] we have a very large number of nurses, but [illegible] and [illegible] do not [illegible] [illegible] and [illegible] [illegible] a [illegible] [illegible] the [illegible] [illegible]

to have adequate nursing staff over week-ends. It is a problem, it is one thing to have a statistic in a book and it is another thing to have the actual person in the right place at the right time.

THE CHAIRMAN: How widespread has been the closing of wards because of the shortage of nurses, as Dr. Sawyer said a few moments ago.

DR. SAWYER: This problem occurs chiefly in new hospitals where they erect a hospital and they have to delay the opening of the wards of some of these hospitals for a period of weeks or even sometimes a few months because of the shortage of nurses. You get into the same thing occasionally, I believe, in the holiday period where the nurses are away and they have to close part of the hospital.

THE CHAIRMAN: Dr. Sawyer, you said this morning that of the students who would enter high school in the Fall of 1955 that at the end of 1960 on 7.6% had the necessary qualifications to enter the health services education stream.

DR. SAWYER: Yes.

THE CHAIRMAN: What do you mean by that? How do you tie that 7.6, to what?

DR. SAWYER: You tie it to the figures in the report of the Minister of Education to the Government and those who have nine Grade XIII papers, which is the requirement for entrance into the majority of health work in this province.

THE CHAIRMAN: Then, is there also an educational percentage, a percentage in marks, any examination percentage?

DR. SAWYER: I did not go into that.

THE CHAIRMAN: It is merely quantitative?

DR. SAWYER: That is true. Some of them have to have 66% in nine papers in order to get into medicine in the majority of universities. I did not go into this, I just took those who had nine Grade XIII papers.

DR. BRUCE-LOCKHART: You appreciate this is a percentage of the number entering Grade IX.

THE CHAIRMAN: Yes, five years later.

DR. SAWYER: Five years later.

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MR. CHAIRMAN: It is merely meant as a

tive?

then have to have five or three years in order to get into medicine in the majority of universe since I do not go into this, I just took those who met in the three mill payers.

this is a percentage of the number entering there is.

The CHAIRMAN: Yes, five years later

L/hm

THE CHAIRMAN: Still on this matter of services, dealing with facilities, you seem to imply that whereas you have a ratio of 3.9 beds per thousand in Metropolitan Toronto as compared with the provincial average of five, that is not enough for Toronto?

DR.SAWYER: That is correct, sir.

THE CHAIRMAN: What is your view of what the top ratio should be?

DR. SAWYER: Well, all we have said there, sir, is that it is 3.9 beds per thousand in Metropolitan Toronto as compared to the provincial average of five.

THE CHAIRMAN: What does that mean? Does it mean anything?

DR. SAWYER: It means that they are a lot shorter than in other places in the province, despite the fact that some of the large hospitals in Toronto have patients funnelled in from all parts of the province and some of them from all parts of Canada because of the special facilities they have there. We can't answer your question today, but there has been set up very recently a committee with the Ontario Hospital Services Commission, the Ontario Hospital Association, our Association and the community agencies of Metropolitan Toronto to undertake a study of the exact requirements of hospital beds and domicillary accommodation in this city. So I think you can accept that a city which has the facilities to treat patients both from within the city and other parts of Canada, if it has less beds than other parts of the province it is

Mr. Chairman: Still on that question of services, dealing with facilities, you seem to imply that whereas you have a ratio of 1.3 beds per thousand in Metropolitan Toronto as compared with the provincial average of 1.4, that is not enough for Toronto?

Mr. Daniels: That is correct, sir.

Mr. Chairman: What is your view of what the top ratio should be?

Mr. Daniels: Well, as I've said there, sir, that it is 1.3 beds per thousand in Metropolitan Toronto as compared to the provincial average of 1.4.

Mr. Chairman: What does that actually mean in terms of beds?

Mr. Daniels: It means that they use a lot more than in other places in the province, despite the fact that some of the large hospitals in Toronto have patients travelling in from all parts of the province and, as we know from our visits, some of them because of the special facilities they have there. We don't consider this a question today, but there has been set up very recently a committee with the Ontario Hospital Services Commission, the Ontario Hospital Association, and Association, and the Community Planning and Development Branch of Municipal Affairs to undertake a study of the bed requirements in Metropolitan Toronto and Ontario generally. It is quite a big job, and it can proceed only at a city which has the facilities to treat patients from other areas. We only can offer parts of Canada, it has long been felt, never be of the proportion it is

in a bad way.

THE CHAIRMAN: Do you accept or reject the idea in the rural areas that the ratio must necessarily be higher?

DR. SAWYER: The rural areas?

THE CHAIRMAN: Yes.

DR. SAWYER: No, I wouldn't accept that it should be higher, and the reason I think you can say that is that in the rural areas and in the smaller hospitals you don't expect the complexity in facilities and diagnostic equipment and the ability to do major surgical operations, open heart surgery and neuro-surgery, and so on. So that the requirement for beds shouldn't be so great in the rural areas as it should be in the larger centres.

THE CHAIRMAN: Do you not accept that in the rural areas the ebb and flow to the hospital will be much more uncertain than in the metropolitan area?

DR. SAWYER: I would ask Dr. Bruce-Lockhart to answer that.

DR. BRUCE-LOCKHART: I see the drift of your question, sir. I think it depends a great deal on how isolated a community is. It is one of our convictions that these things should be dealt with as local problems and we don't approve of this averaging concept. As a matter of fact, we took the trouble to see if we could get any evidence, any paper on requirements on beds per thousand, and a search of all the medical libraries available did not turn up one paper. It is very much a local thing, but in considering this

local thing you have to take off the percentage of cases that have to go to a big centre nearby and therefore the big centre represents beds for that local community. And, of course, it seems to change all the time, where one centre, in my own area in the north where we have improved our facilities where people who would have gone to Toronto would stay with us. We are very reluctant to answer your question, and without sort of shooting our necks out in any way we don't believe that this can be assessed in terms of local situation, and we are merely using this in terms of the extent, and that is all.

THE CHAIRMAN: I think it is on page 60 that you have some figures or rather in paragraph 195 you list several categories of persons eligible as of the 31st of December, 1961, for assistance from the Department, and you arrive at a total of 221,412. Now, that 221,000 are quite unable to pay any premiums or costs?

DR. SAWYER: That is correct, sir.

THE CHAIRMAN: Then we have another area that you recognize on page 61, paragraph 198, that you call the marginal income group. Are you able to give us any estimate of what that figure is for the Province of Ontario?

DR. SAWYER: Mr. Chairman, we can't give you any estimate of the number. We have had discussions with the Minister and Deputy Minister of Public Welfare, and we also tried to ascertain information from the Department of National Health and Welfare,

but we have not been able to delineate the exact numbers. And the reason for this, of course, is obvious, that the circumstances of people change and their conditions change. For instance, you might have a person making a very small wage but they may be employed where the employer pays 100% of a fairly comprehensive medical care plan. So on any discussion with the Minister and Deputy Minister they have agreed to give this problem further consideration. They realize it is a complex one, and we are going to have further discussions with them where we hope to be able to provide the answers to the questions which you have asked.

THE CHAIRMAN: Well, if those figures should become available in the next few months we would certainly like to have the benefit of any information you might be able to give us in that respect.

DR. SAWYER: We would certainly be happy to provide it, sir.

THE CHAIRMAN: I think there is another group that I suppose we have to have in mind and that is a group of practically all ages and perhaps of all income who are medically uninsurable, and you recognize that that is another segment of the population. Have you any idea of the size of that segment in Ontario?

DR. SAWYER: I would ask Dr. Atkinson to speak on that.

DR. ATKINSON: Mr. Chairman, this would be very difficult to assess because of the present mechanisms in action in this province. Certainly these people have coverage ---

THE CHAIRMAN: That is their group?

DR. ATKINSON: Yes, through their group, and then become difficult or fall into a group that become uninsurable, but they are able to continue their coverage. The doctor-sponsored plans, P.S.I., Windsor Medical Service fall into that category, and indemnity plans provided by the insurance carriers. The problem is one which is difficult to assess because this is a changing thing and we would be unable to provide any accurate figures on this particular problem.

I would also point out, Mr. Chairman, that this is a diminishing problem as the normal mechanisms of prepayment are extended, realizing that in the last ten years there has been a remarkable growth, and this was indicated in the remarks made this morning, of some 20% to 25% up to something over 60% getting coverage, and the extension of the plans to cover those who reach the age of normal retirement which are carried on either through the group plans in their previous place of employment and the doctor-sponsored plans, and coverage in community enrolment which has recently started in this province in certain areas and which is an expanding programme at the present time.

THE CHAIRMAN: Dr. Sawyer, I may move over to an entirely unrelated field. On page 72 of your brief, paragraph 243, where you are talking of the service of the private practitioner in evaluating new drugs, procedures and techniques. We hear quite a lot about the drug detailman. Has the Ontario Medical Association any opinion to offer on the value that the

so-called drug detailman has as on the necessity of the day-to-day education of the practising physician in the use of new drugs?

DR. SAWYER: No, sir, the Ontario Medical Association has no opinion on that subject.

THE CHAIRMAN: Where should this Commission go for such an opinion?

DR. SAWYER: If you wish an opinion on it, sir, we would be happy to give it consideration. But I think you appreciate that we are trying to answer the question within the policy that has been established by the Association.

DR. BRUCE-LOCKHART: What Dr. Sawyer is saying is if you specifically ask us for an opinion we would be happy to evaluate the situation and give you one.

THE CHAIRMAN: I think we would be happy to accept that offer.

COMMISSIONER BALTZAN: Mr. Chairman and gentlemen, I would address myself to Dr. Bruce-Lockhart and say that the Commission is very much interested on this stress you have put on the human side as a feeling of interest on the subject we are engaged in.

In pursuing that it seems to me that you were trying to arrive at an equation of the human unit value in terms of the dollar unit value, which brings in what it would save for the individual and what it would save in terms of cost.

In your thinking, Dr. Bruce-Lockhart,

have you or can you arrive at something of what might be of a mathematical order which would help us in this very challenging problem, that is the human values that you speak of and with which everybody is concerned, the cost in relation to these things covered by what you have termed as the human requirement? If that is too broad a question -- I know you have done a lot of thinking -- if you want to think it over and help us later we would appreciate it.

DR. BRUCE-LOCKHART: I wanted to be sure that I understand the question first, sir, if I may. You are suggesting that there is a relationship between human values and monetary values?

COMMISSIONER BALTZAN: We are forced to think of that relationship. How can we actually formulate that in terms of costs? Let's put it this way. An impending coronary, for safety would he be better to be put into a hospital for safety at the expense of $20.00 a day or wait until the coronary exploded to justify his condition?

DR. BRUCE-LOCKHART: I don't think there is any doubt, sir, in that particular example you gave. The medical profession has always been in the habit of not considering cost in relation to need. If a man needs something the profession has traditionally and always said he must have it if it is in the interest of his safety. I don't think we can stop and say is this going to cost so much. If we are concerned with safety we go ahead. That is why I find it difficult to answer your original question, because as far as we are concerned we feel, probably to answer the question basically, that it costs what is necessary. I don't see how you can really answer this in any other way.

COMMISSIONER BALTZAN: Quite.

DR. BRUCE-LOCKHART: The only thing is we don't want to see there is so much money available and you do the best you can with it.

COMMISSIONER BALTZAN: It is the human element?

DR. BRUCE-LOCKHART: Yes.

COMMISSIONER BALTZAN: Thank you very much. I think you have helped me. If you could come up with a formula it would be very nice.

DR. BRUCE-LOCKHART: I wish we could too.

COMMISSIONER BALTZAN: I am very much interested in the condition of your appendix. I would say it is quite healthy, quite bulky, but not swollen, blue, but not syancosed. May I just have one or two

simple questions without dissecting the appendix. I notice you have at least 20 working committees on the projects, is that right?

DR. SAWYER: That is correct, sir.

COMMISSIONER BALTZAN: May I ask you this, who finances these projects, these study features in your Ontario Medical Association programme?

DR. SAWYER: They are financed in a variety of ways. Some of them we get grants from places like the Atkinson Foundation. In the R. H. programme we had assistance from the Junior Red Cross. You understand that this supplies a portion of the money involved. The expenses of the work of our committee are paid by our own association, that is if they have to come into meetings we pay their travelling and maintenance expenses and we supply office facilities.

COMMISSIONER BALTZAN: That comes out of the fees you collect from your membership?

DR. SAWYER: That is right.

COMMISSIONER BALTZAN: These committees have been in operation over the years. It is not something that is current.

DR. SAWYER: It goes back to 1881, sir.

COMMISSIONER BALTZAN: Thank you very much. I don't remember that year. Are these Committees intended -- I presume, or they tell me, to elevate the standards and preserve the integrity of the medical profession?

DR. SAWYER: Yes.

COMMISSIONER BALTZAN: And they contribute towards the progress of the development of medicine for the greater benefit of good medicine for the people?

DR. SAWYER: That is correct, sir.

COMMISSIONER BALTZAN: I shall finish now, Mr. Chairman, but a very brief reference to Dr. Sawyer's remarks as he is quoted on pages 116 and 117. I would say to you, Dr. Sawyer, it has helped my thinking a good deal in respect to the very sharp statement you made about certain things being taken out of context having different meanings. My specific question is at the bottom of page 116, number 10:

> "If, in spite of allowing a doctor "some of the things he wants such as "fee-for-service, it ends up by making "government the sole purchaser of his "services, then it is a plan that "should be opposed."

Would you say an extension of the same reasoning, Dr. Sawyer, that a national plan or some such uniformity would intensify this problem, say, by excluding provincial governments from competing for the services of individuals?

DR. SAWYER: Yes, if there was a regulation that went along with it, sir, which made, in fact, the government the sole purchaser of medical services.

COMMISSIONER BALTZAN: If it was country-wide?

contribute towards the purchase of the government's medicine for the great benefit of our returning to the people?

Now, Mr. Chairman, our a very brief reference to Mr. Sawyer's remarks as he is quoted on pages 111 and 112. I would say to you, Mr. Sawyer, if he judged by the good deal of money it to the very strong interest you made also a certain thing being taken out of workers having different measures. My speech is at the bottom of page 111, number 10.

"I ... measure of allowing a doctor
"some of the things he wants such as
"the discretionary, I ... to ... by ...
"prescribed the right purchase of ...
"advices, from it be a ... that
"... be opposed."

Now, if you say ... the ... Minister ... Sawyer ... that a national plan or some such uniformity would internally this province, say, by ... the provincial government ... corporation ... be serious ... of industries.

Mr. CHAIRMAN: Now, if there was ... suggestion that ... along with it, such ... in ... the government ... some ... ...

Mr. [illegible]: It is ...

DR. SAWYER: That would be worse still.

COMMISSIONER BALTZAN: It could be worse. Mr. Chairman, I will have to pass by. I lost track of where I was going to go next.

THE CHAIRMAN: Dr. Firestone.

COMMISSIONER FIRESTONE: Dr. Sawyer, I would like to congratulate you and your associates following the remark the Chairman made about the comprehensiveness and the high quality of your submission. It has been extremely helpful.

I shall concentrate on questions, sir, if I may, dealing with the questions of policy and principle rather than getting involved in questions of details and statistics. If any of these questions come up I would be happy if you would provide the information at a subsequent time. My first question, sir, is your Association in favour of a comprehensive medical care programme for the Province of Ontario?

DR. BRUCE-LOCKHART: We have to be very careful of words, sir. If you mean by this, is the Medical Association in favour of a master plan of any type of comprehensive care under central control for Ontario, the answer is, no. If you mean are we working towards making medical care comprehensively available as fast as we can, the answer is, yes.

COMMISSIONER FIRESTONE: Are you, therefore, in favour of policies and efforts that move in the direction of providing a comprehensive medical care programme for the Province of Ontario?

DR. BRUCE-LOCKHART: Provided it is not under one head, sir.

COMMISSIONER FIRESTONE: We will come to the organization of the programme later. At the moment, just deal with comprehensive medical care programmes. I take it the answer is you are in favour of such a principle?

THE CHAIRMAN: I didn't understand him to say that.

DR. SAWYER: I think you have to explain, perhaps, Dr. Firestone, the meaning of the word "provided".

COMMISSIONER FIRESTONE: Of course this is up to the Ontario Medical Association to tell us what they have in mind when they speak of it in that they are working towards the development of such arrangement of comprehensive medical care services in the Province of Ontario. What do you have in mind?

DR. BRUCE-LOCKHART: We have in mind, sir, that the present system of providing medical care in this province has proved satisfactory, with certain areas of lack, which we have outlined. We feel that this evolutionary process should continue. We have outlined in the brief in some considerable detail what we mean by the present process. If it is allowed to continue and is helped in certain specific areas by all the various people, sir, which includes government in its role, the voluntary agencies in their role, the medical profession in its central role then we will achieve the comprehensive medical care for the Province

of Ontario.

COMMISSIONER FIRESTONE: Are you suggesting, sir, that the Association is satisfied with the existing medical care programme or plans as they are in existence in the province today?

DR. BRUCE-LOCKHART: I think, sir, you will see in the brief we see many areas where improvement is required, but we are confident that improvement is occurring and occurring in a way that will not necessitate us taking a back-step through having made major mistakes.

COMMISSIONER FIRESTONE: Would you be in favour of perhaps speeding up this process of providing increased medical care service for the people of Ontario?

DR. SAWYER: What do you refer to, Dr. Firestone? How would this be speeded up?

COMMISSIONER FIRESTONE: I am just enquiring whether you feel this process of evolution should be allowed to take place in the marketplace of the type that has taken place in the past or whether you would feel the people in the Province of Ontario would like to have a comprehensive medical care programme without having to wait another ten, twenty or thirty years until that process of evolution would provide the sort of situation you suggest?

DR. SAWYER: I think to answer the question we would have to know by what means you are going to speed up this evolutionary process. If you would like to explain that I think we could give you an answer to your question.

of Ontario.

[illegible] that we have [illegible] identified [illegible] medical care or [illegible] or plans [illegible] they are in existence in the province today.

You will see [illegible] we see many areas where improvement is required, but we are just that improvement in accounting and [illegible] in a way that will lead necessarily to [illegible] a [illegible] through making more [illegible].

[illegible] or [illegible] or perhaps [illegible] up the [illegible] of providing increased medical care [illegible] people of Ontario.

[illegible]: What do you [illegible] by increased? How would this be [illegible] up?

[illegible]: I [illegible] arguing whether we need this process of evolution should be allowed to take place in the development of the type that has taken place in the past or whether we would feel we have the resources of Ontario [illegible] to have a comprehensive medical care program without having to wait another ten, twenty or thirty years for the process of evolution [illegible] the sort of [illegible] you suggest.

[illegible]: I think [illegible] [illegible] to know by what means you are [illegible] [illegible] [illegible]. It was [illegible] to say to you that I think we could give an [illegible] to your question.

COMMISSIONER FIRESTONE: Well, sir, I would like to have an answer from your Association to find out whether you are satisfied with the progress that has been made through your process of evolution or whether you are in favour of that process being speeded up. If your answer were yes I would ask you how you would suggest we do it. If you are suggesting that the process of evolution without doing anything about it that is all you have to say.

DR. BRUCE-LOCKHART: I would like to say we are amazed and satisfied with the rate of progress that has gone on in the last ten years. We feel it is a sure progress. We are not satisfied with the status quo. We are constantly working. We have all these committees working on improving it. We are as interested in improvement, probably more interested, because it affects us more than anybody else. We feel this work has gone extremely well and should continue.

COMMISSIONER FIRESTONE: You appreciate, sir, there are groups in Ontario representing a lot of people, whether a workers' group, farm group or other consumers of medical care services who feel that the progress we have been making in Canada is not adequate. There seems to be a difference of opinion. You, the providers, say you are satisfied, but there are many receivers of services who say they are not satisfied. This Commission has been called upon to offer advice to the Federal Government. My question to you is, if we take seriously the views expressed by the receivers of medical care services that the progress

CHAIRMAN VAN TIMBERGEN: Well, sir, I would like to have an answer from your Association to find out whether you are satisfied with the progress that has been made through your process of conciliation or whether you are in favor of that process being speeded up. If you do not mind, I would like you how you would support us to do it. If you are suggesting that the process of conciliation was done, whether such is all you have to say.

Mr. [illegible]: I would say to say we are satisfied with the rate of progress that has gone on in the last two years. [illegible] a slow progress. We are not satisfied with the rate of progress. We are committed, workers, to have committees working on improving it. We are in favor of improvements, perhaps more interested because [illegible] we have the [illegible] stage. We feel that work is going successfully and should continue.

[illegible]

Mr. [illegible], Western [illegible] Industrial Group, Iron Group on other industries [illegible] and all other [illegible] who feel that the programs we have [illegible] for dealing in Canada is not adequate. There seems to be a difference of opinion [illegible], for [illegible], are you satisfied, or the [illegible] Industrial Relations [illegible] who say they are not satisfied. That [illegible] has been called upon to offer advice to the General Committee. My question to you is, is we have seen only the views expressed in the briefs of [illegible] service that [illegible]

has been inadequate the question arises what can be done to speed up that progress, the process of evolution which you described?

COMMISSIONER BALTZAN: Dr. Firestone, Dr. Bruce-Lockhart; perhaps we could answer this faster if I put one question: Is there an urgency, an extreme urgency for rapid speeding up?

DR. BRUCE-LOCKHART: I don't think so, sir.

COMMISSIONER FIRESTONE: With all due respect to my fellow Commissioner, my question was related to the desires and the wishes that a large number of people have been expressing to the Commission through their organizations. It isn't a question of whether in the opinion of the doctors it is an urgent matter or not. The receivers of medical services have been saying to us in their opinion it is an urgent matter. We come to you as the providers of medical services and we are asking you, we have to deal with these proposals and these requests that have been put before us, can you suggest anything -- how this process of evolution can be speeded up to meet the demands which this Commission has been receiving from many recipients of medical care services or groups representing recipients of medical services?

DR. BRUCE-LOCKHART: We maintain, sir, that there are urgent needs, and we have outlined them. They are namely, and in the main, in the provision of facilities and the improvement of the attitudes and services in the mental health field. These are, to us,

the most urgent needs, and we have suggested how this should be approached. We have further acknowledged and we always have acknowledged that there is an area of problem with the indigents and with, what we call the marginal income group. We have approached governments about this. Directly government is interested, but is concerned about finances. This is the answer we have received. The Provincial Government says, gentlemen, we haven't the finances to do this and unless the Federal Government will assist us we cannot.

the most urgent crisis, and we have suggested how this should be approached. We have further acknowledged and we always have acknowledged that there is an area of problem with the moneyers and with, what is still the monetary income group. We have approached government's about this. Directly government is interested, and is concerned about income. This is one answer we have received. The Provincial Government says, gentlemen, we haven't the finances to do this and unless the federal government will assist us we cannot.

We are concerned, yes, but we are very much afraid of any rush. We think it's very simple. Any person who is not directly involved in any field can look at it superficially and say, "We want quick action. Do something now." They aren't having to produce it. They aren't having to do it. They don't understand the complexities of the situation and if they say to me, put a pistol at my head "Do something", my reaction is: Well, I mustn't do harm.

COMMISSIONER FIRESTONE: Well, this is a very reasonable point of view, and we quite understand it, and accept it. Nobody wants to rush into any plan that is ill-conceived and unconsidered, but the fact remains that we would like, or at least a lot of people would like to make more rapid progress and if I understand your answer correctly, you are in favour of such speeding-up process, because you have made a number of recommendations in this report, in this brief. Am I correct in that understanding?

DR. BRUCE-LOCKHART: We are in favour of the recommendations we have made being looked at seriously and being implemented where possible, sir, but I do not wish to leave you with any impression that we are in favour of speed, because we are not.

COMMISSIONER FIRESTONE: My question was not of speed, but speeding. As you know, speeding is a matter of degree. By leaving things to evolution, you leave it then to natural forces, and we say if it is a problem, and a lot of people think so, natural forces have been too slow.

Any person who is not directly involved in any field can look at it straightforwardly and say, "We can think of a solution, for something, or" They aren't having to produce it. They aren't trying to do it. They don't understand the complexities of the situation and it they say to me, put a stress on my head "Do something", my reaction is: well, I hate to have

CONVERSATIONALIST FRANCOVICH: Well, this is a very reasonable point of view, and we quite understand it, and accept it. Nobody wants to [illegible] any plan that is ill-considered and unfortunate, or the [illegible] that we would [illegible], or at least [illegible] [illegible] [illegible] [illegible] [illegible] understand your answer correctly, you are in favour of some speeding-up process, because you have made a number of recommendations in this report, in this brief. Am I correct in that in [illegible]?

Dr. BUDZ-LUKIANOV: We are in favour of the recommendations we have been being looked at seriously and being implemented where possible, sir, but I do not wish to leave us with any impression that we are in favour of speed, because we are not.

CONVERSATIONALIST FRANCOVICH: My question was not of speed, but speeding. As you know, speeding is a matter of degree. A lot of driving things [illegible] [illegible] it then on natural levels, and we saw if it is a [illegible], and a lot of people [illegible] natural [illegible] [illegible] [illegible].

DR. BRUCE-LOCKHART: I realize that some people think that. We think they have been extremely quick. We think the progress has been extremely fast, sir.

COMMISSIONER FIRESTONE: In other words, you do not agree with the views that progress has been inadequate and more rapid progress should be made?

DR. BRUCE-LOCKHART: In certain fields, such as provision of facilities, I feel that attention is important in these areas. We have mentioned it, sir. I am just objecting to the idea that we are suggesting that it wants speed, because we don't think speed is wise.

DR. ATKINSON: I think, Mr. Chairman, our concern is that the total medical care needs of the people of this Province, and indeed of the Dominion should not be considered in terms of these very clearly defined areas of immediate need, as far as we see it. Again, mental health services, rehabilitation and we have indicated that we have concerned ourselves with those in the marginal income group and sought means of looking after these people, but we would emphasize that the medical care needs of the population as a whole should not be considered in terms of the need to get on with the job in this particular area.

COMMISSIONER FIRESTONE: When we are talking of medical care services, I take it, sir, that you have in mind comprehensive medical care services made available to the Province of Ontario? To the people of the Province of Ontario?

DR. SAWYER: Yes. That is correct.

COMMISSIONER FIRESTONE: Would comprehensive cover physical and mental health, and would it

Mr. McLelland: I realize that some people think that. We think they have been extremely quick. We think the progress has been extremely fast, sir.

CHAIRMAN: In other words, you do not see with the very fast progress has been inadequate and more rapid progress should be made?

such as provision of facilities, I feel that attention is important in these areas. We have mentioned it, sir, I am the objecting to the idea that we are suggesting that it ends soon, because we don't think speed is wise.

Mr. ATKINSON: I think, Mr. Chairman, our concern is that the total medical care needs of the people of this Province, and indeed of the Dominion should be considered in terms of these very clearly defined areas of immediate need, as far as we are it. Again, mental health services, rehabilitation and we have indicated that we have concerned ourselves with these in the material income group and sought means of looking after these needs, but we would emphasize that the medical care needs of the population as a whole should not be considered in terms of the need to get on with the job in

CHAIRMAN: When we are talking on medical care services, I take it, sir, they have included comprehensive medical care services now available to the Province or district to the people of the Province or Canada?

Mr. McLELLAN: Yes. That is correct.

cover preventive as well as curative medical services?

DR. SAWYER: Of course.

COMMISSIONER FIRESTONE: Would you say that such plans or programs, as they are developed, should become universally available without regard to the financial means at the disposal of any individual or his family?

DR. SAWYER: Are you talking now of -- you have moved now from service into the question of prepayment plans, sir?

COMMISSIONER FIRESTONE: Well, if you wish to put it this way, I will restate my question: Is the Ontario Medical Association in favour of the principle of prepayment?

DR. SAWYER: Yes.

COMMISSIONER FIRESTONE: When it then comes to paying, would you say that you are in favour of a system whereby those that can pay the premiums, or whatever form their prepayment takes, do so, and those that cannot pay the full cost of that premium, or part of it, have that premium, either in full or in part, paid by the State?

DR. SAWYER: Yes.

COMMISSIONER FIRESTONE: Therefore, would you say, sir, Dr. Sawyer, that you accept the principle of financing such a medical care program in the Province of Ontario as being the principle of the ability to pay for such service?

DR. SAWYER: The principle of ability ---?

COMMISSIONER FIRESTONE: Of the ability to pay?

DR. SAWYER: Yes. That those that can pay should have that responsibility.

COMMISSIONER FIRESTONE: May I take it your suggestion is, and you have dealt with it in your brief, that those who cannot pay have their premium paid by the State? Is that correct?

DR. SAWYER: Yes. That is in our brief, sir, yes. It is contained in our brief, sir.

COMMISSIONER FIRESTONE: Now, in defining what you mean by State, do you have in mind the Provincial Government? Do you have in mind the Federal Government, or do you have in mind the Provincial Government with a contribution from the Federal Government?

DR. SAWYER: Well, sir, we deal only with the Provincial Government. We are a Provincial Association and our dealings, in matters of financing of these things, we deal with our own Government, of course.

COMMISSIONER FIRESTONE: Therefore, your answer, if I understand you correctly, sir, is that when you speak of the State, you refer to the Provincial Government?

DR. SAWYER: That is correct.

COMMISSIONER FIRESTONE: May we turn, sir, to Paragraph 143 on Page 42, where you discuss the role of Government in any plan or program that might be developed, and you point out in the first paragraph on Page 42, that Central Government has three advantages over any other section of the community. Do I take it that the word "Central Government" in this context means Provincial Government?

DR. SAWYER: Yes.

COMMISSIONER FIRESTONE: Thank you.

DR. BRUCE-LOCKHART: That is Central Government, Provincial Government, sir, as opposed to municipal government.

THE CHAIRMAN: Item 3, Provincial Treasury.

DR. SAWYER: Yes.

COMMISSIONER FIRESTONE: You speak in Paragraph 201, I think Dr. Bruce-Lockhart, you made reference to it in a verbal comment. The Provincial Government has explained to you that for financial reasons it would be unable to extend the provisions of the medical care plan presently applicable to indigents, to what we may call the medically indigent group until, and I quote, "Such time as the Federal Government made an appropriate contribution towards the cost."

Now, sir, you say you are dealing here with the proposals concerning the Provincial Government. The Provincial Government has explained to you that it cannot proceed with some of the proposals which you have made unless it gets some financial assistance from the Federal Government. Would you, therefore, be in favour of a program or a plan that would involve the Federal Government making a financial contribution to a Provincially administered plan?

DR. BRUCE-LOCKHART: Well, we are up against a problem here, sir, and that is that health is a provincial matter and we look and deal with our Provincial Government. We look to them, so that we really do

Mr. A. MYP Sir,

That is central government, Provincial Government, sir, as opposed to municipal government.

Mr. CHAIRMAN: Item 3, Provincial

CONSTITUENCY PROGRAM You speak in paragraph 2(b), I think the, Mr. Chairman, you made reference to it as a vague comment. The Provincial Government has explained to you that for financial reasons it would be unwise to extend the province and the municipal zone plan presently applicable to Inuvik, to include the outlying predominantly indigent group there, and I quote, "such time as the Federal Government makes an appropriate contribution towards the cost."

Mr. , Sir, you say you are dealing here with the proposed amending the Provincial Government. The Provincial Government has explained to you that it cannot proceed with some of the proposals which you have made unless it gets some financial assistance from the Federal Government. Would you, the chairman, be in favour of a program or a plan that would involve the Federal Government making a financial contribution to a presently deficit ridden budget?

Mr. MACDONALD: Well, we can be against a wooden nickel, sir, and that is that health is a provincial matter and we have had all kinds of Federal assistance. We have to, sir, so that we really do

not feel that what the Provincial Government does between them and the Federal is directly, so to speak, our concern.

It is, however, indirectly our concern and one of the concerns that we have is that, just as any medical care within our Province, we feel very strongly that the individual is what counts, the local community counts next, and then the whole province last.

In the same way, when dealing with the Federal-Provincial relationship, we are concerned about any overall plan that might thrust something on Ontario, to average it across the Dominion which would not be exactly suitable to Ontario conditions.

Now, we are indirectly concerned in that way.

COMMISSIONER FIRESTONE: But realizing that you have come forward with what we consider, what one may consider as a very comprehensive proposal. You have been told by the Provincial Government it may be a good idea, but we cannot go ahead until we get some more money from the Federal Government.

Now, I would like to go back to the earlier statement I made where I spoke of a Provincial Plan, a Provincial Government Plan. My question still is, sir: If you are interested in seeing the Provincial Government adopt that plan and they tell you that they are waiting for some Federal assistance, would you, as an Ontario Medical Association, support such an arrangement?

We are here trying to advise the Federal Government and we have to come to the medical

not feel that what the Provincial Government does between them and the Federal is directly, so to speak, our concern.

It is, however, indirectly our concern and one of the concerns that we have is that, just as our municipal care within our Province, we feel very strongly that the individual is what counts, the local community counts next, and then the whole province can.

In the case we, when dealing with the Federal-Provincial road problem, we are concerned about any overall plan that might thrust something on Ontario to arrange it across the junction which would not be exactly suited to Ontario conditions.

Now, we are find worth consideration in that way.

That you have come forward with what we come up, what one may consider as a very comprehensive proposal. You have been told by the Provincial Government it may be a good idea, but we cannot go ahead until we get some more money from the Federal Government.

Now, I would like to go back to the previous question. The whole idea I gave of a Provincial Plan, a Provincial Government Plan. My question still is, if you are interested in seeing the Provincial Government adopt that plan and they tell you that they are waiting for some Federal assistance, would you, as a municipal federation, support such an arrangement?

We are here asking to endorse the resolution and we want to come to the Federal

profession in each Province and say, do you support such a plan and what are your views?

DR. SAWYER: Mr. Chairman; I think we should say this, that we deal with our Provincial Government and in this instance we have laid before the Department of Public Welfare what we consider to be a need in the Province of Ontario. Now, it is assumed that if the Department of Public Welfare agrees that there is a need in this area and that it has not sufficient funds to meet the need, that it will try and obtain those funds.

Now, our concern about the Federal - Provincial agreements is simply this: That if you seek money for a specific purpose from, say, the Federal Government, then you will have regulations tied to that amount of money which often hamstring and limit the program required in the Province and it is our view that we deal with our Provincial Government.

If it hasn't sufficient money, it should try and get it from the source available to it and with that money should develop programs which are suitable to our Province. If that would answer your question.

DR. GALLOWAY: I was not going to say very much more than that, sir, because when you use the word "plan" I wanted to make clear whether you are thinking of an overall plan for all people in the country, or in the Province, or whether you were speaking of this particular plan that Dr. Bruce-Lockhart was speaking of.

COMMISSIONER FIRESTONE: My question referred to Paragraph 201 and it was raised in that context,

production in such instances are say, do you support such a plan and what are your views?

Mr. SAVAGE: Mr. Chairman; I think we should say this, that we deal with our Provincial Government and in this instance we have laid before the Department of Public Works what we consider to be a need in the Province of Ontario. Now, it is assumed that if the Department of Public Works agrees that there is a need in this area and that it has not sufficient funds to meet the need, that it will try and obtain those funds.

Now, our concern about the Federal Provincial agreements is simply this: That if you seek money for a specific purpose from, say, the Federal Government, then you will have regulations tied to that amount of money which often hamstring and limit the program required in the Province and it is our view that we deal with our Provincial Government.

If it hasn't sufficient money it should try and get it from the source available to it and with that money create develop programs which are suitable to our Province. That would answer your question.

Mr. CALLAWAY: I was not going in any much more than that, sir, because when you use the word "plan" I was so to make clear whether you are talking of a overall plan for all people in the country, or in the Province, or whether you were speaking of this particular plan that the Prince-Lockman was speaking of.

Mr. CHAIRMAN: I interpret in question referred to Hansard 7-1 and it was raised in that context.

and I think the answer that I received was also in that context.

DR. SAWYER: That is right.

COMMISSIONER FIRESTONE: Am I correct in that understanding?

DR. SAWYER: That is quite correct.

COMMISSIONER FIRESTONE: Now, sir, to come back to the basic question: Here you have come forward with some constructive ideas and you have been told by a Government we have not got the money. However, if the Federal Government participates we might be able to do something about it or at least the Provincial Government is prepared to consider it.

Now, we are supposed to make some recommendations to the Federal Government and unless we get some advice from the people that will be carrying out services under such a plan, where should we turn to obtain such advice as to whether the Federal Government should or should not contribute to such a program as you recommend in Paragraph 201?

THE CHAIRMAN: You mean we want the Ontario Medical Association now to become our financial advisor?

DR. SAWYER: That is the point I was going to make, with respect, Mr. Chairman. I think it is not our duty to do more than lay before responsible bodies, such as our own Provincial Government, needs in the area of health where we feel that they have a responsibility.

Now, I do not think that we should tell them, nor, with respect, do I think we should tell

you where they are going to find the money to finance this program, if they agree with it. They have indicated that if they got money from the Federal Government this would be fine. They have Dominion - Provincial meetings on matters of finances and I assume that this would be one of the areas that might be discussed in the needs of the Provincial Government.

COMMISSIONER McCUTCHEON: They may simply say we need more money without saying how they are going to spend it.

COMMISSIONER FIRESTONE: Are you suggesting that you are not in a position to offer the Commission any advice on financing or economic aspects of medical care service to be provided the Province of Ontario?

THE CHAIRMAN: That is not what I understood the answer to be, Mr. Firestone.

[illegible] where they are going to find the money to finance the program, if they agree with it. They have indicated that if they get money from the federal government this would be fine. They have tremendous - practically unlimited on matters of finance and I assume that this would be one of the areas that might be discussed in the case of [illegible].

COMMISSIONER [illegible]: They may actually say we need more money without saying how they are going to spend it.

[illegible]: We are suggesting that you are not in a position to offer the commission any advice on financing or economic aspects of medical care services to be provided as [illegible] [illegible].

[illegible]: [illegible] is not what I [illegible] the answer is by Mr. [illegible].

PMcH/dpw

COMMISSIONER FIRESTONE: If you will explain your own views I would be happy to have them.

DR. SAWYER: I have given them as explicitly as possible; the views that we hold.

COMMISSIONER FIRESTONE: Well, I am looking at paragraph 5 on page 295 - it is really sub-paragraph 5 of paragraph 6 on page 295 in which you recommend:

"The medical profession as the provider of physicians' services must have the right and in the public interest, the responsibility to:

5) Maintain mediation committees to deal with complaints, from whatever source, be they medical, ethical or economic and respect the recommendations made by these committees."

I take it you are concerned with economic questions?

DR. SAWYER: Oh, yes.

COMMISSIONER FIRESTONE: Would a question of finance not be an economic question?

DR. BRUCE-LOCKHART: If I might just try - I think what you are trying to obtain from us is, if the Federal Government were to proceed in any direction, in what direction would we prefer to see them proceed?

COMMISSIONER FIRESTONE: That is well understood.

DR. BRUCE-LOCKHART: What we are saying is, we would prefer that health matters be a provincial

matter and that if money comes from the Federal Government it should come without any strings attached to it for health purposes or the province should deal with it as it finds necessary in the province.

COMMISSIONER McCUTCHEON: You might deal with it and build roads.

DR. BRUCE-LOCKHART: It is this business in mind.

COMMISSIONER FIRESTONE: I do not know if the subject of health is not your business ---

DR. BRUCE-LOCKHART: If the money is allocated for health it is our business.

COMMISSIONER FIRESTONE: Exactly; I am glad you said that. If I might continue on this question of financing, after all, if we have found an answer as to where the money will come from, it would help a good deal to formulate a program that might be acceptable to the medical profession and the recipients of health services and other groups as well.

You have in the Province of Ontario a hospital insurance plan in operation?

DR. BRUCE-LOCKHART: Yes, sir.

COMMISSIONER FIRESTONE: Is the Ontario Medical Association satisfied with the operation of that plan in overall terms? I am sure there must be a number of specific medical details which can be improved but I would prefer not to get involved, at this stage, in any details but just deal with the broad principles on which this plan is based.

Are you in favour of the principles on

[illegible]

matter and that if money comes [illegible] interest [illegible]
it should come without any strings attached to it for
health purposes or the [illegible] should deal with it as
it finds necessary in the service.

CHAIRMAN [illegible]: [illegible] right
then with [illegible] to [illegible].

[illegible]

in mind.

C. [illegible] [illegible]: I do not have
if the subject of health is not your business.

Dr. [illegible]: If the money is
allocated for health it is our business.

[illegible]: [illegible] I do
[illegible] [illegible]. If I have convinced on this question
of financing, then will we have time to [illegible] as
to where the money will come from, it would help a good
deal to demonstrate a program that might be accepted e to
be radical or [illegible] and the possibility of [illegible]
[illegible] and other groups as well.

[illegible] in the Province of Ontario a
[illegible] insurance plan or [illegible]?

[illegible]: [illegible], sir.

[illegible] Association [illegible] the [illegible] of that
[illegible] in several ways. I [illegible] that be a number
of [illegible] [illegible] which may be [illegible] but I
[illegible] to be involved, at the start, in any
[illegible] that deal with the good principles on which
this plan is based.

[illegible] the [illegible] of the [illegible] on

which this plan presently operates?

DR. BRUCE-LOCKHART: The answer to that is, we have to try and be fair. I think it is important the plan has only been in operation two years. At the same time, the answer to your question directly is no.

COMMISSIONER FIRESTONE: Could you give us your reasons for your answer being no?

DR. ATKINSON: Mr. Chairman, I think that our basic concept in providing an answer of no is that this plan has had a very short period of time to operate. We cannot see clearly into the future as to what will happen between the local hospital and the Commission.

Also, we see some areas of concern because the operation of the local hospital is dependent on funds provided from a central organization. In other words, this brings us to the problem of central control and, again, this brings in the averaging process which we do not feel should apply because of the wide nature, the varied economic climate of this particular province.

What would apply in a metropolitan area such as the City of Toronto has a great variation from what would apply to areas in Northern Ontario.

We can see points of concern. At the present time the hospitals must operate within a budget that is fixed or approved by the Hospital Services Commission and this, in turn, will affect the salaries paid to nurses and to other para-medical personnel within the hospital. This has an effect; again coming back to our basic submission of concern regarding personnel and

[illegible]

[illegible]

[illegible]

[illegible] The answer is that [illegible] I think it is impossible [illegible] at the [illegible] to your question [illegible] is no.

[illegible] Chairman, [illegible] us your reason [illegible] answer being no?

[illegible] Mr. Chairman, I think that our laws [illegible] an answer [illegible] no is that this plan has had a very short period [illegible] operation [illegible] I cannot see [illegible] into the [illegible]

[illegible]

[illegible] the operation of the local hospital is [illegible] on [illegible] a central organization. In other words, this brings us to the problem of central [illegible] and, again, this lady in the average [illegible] is not [illegible] should apply because of the wide nature, [illegible] economic [illegible] of this particular [illegible]

[illegible] apply in a [illegible]

[illegible]

[illegible] are points of [illegible] at the [illegible]

[illegible] is found on [illegible] by the [illegible]

[illegible] I [illegible] to other [illegible] between [illegible]

[illegible]

the fact that there should be adequate facilities, there should be adequate remuneration, there should be adequate incentive to keep these people in these fields because of our growing economy and rapidly expanding population.

COMMISSIONER FIRESTONE: How do you feel, and I address this question to you, Dr. Sawyer, but please feel free to ask any of your colleagues to deal with it if you so wish; how do you feel about the principle that this Ontario Hospital Insurance Plan has this almost complete coverage - not quite complete, perhaps 95% plus or minus - how do you feel about this principle of this almost universal coverage?

DR. SAWYER: You mean how do we feel about the principle of compulsion?

COMMISSIONER FIRESTONE: Compulsion plus voluntary; it is a combination of the two.

DR. SAWYER: I would ask Dr. Galloway to speak about compulsion.

COMMISSIONER FIRESTONE: Compulsion and voluntary.

DR. GALLOWAY: We have some fairly strong feelings about compulsion. We recognize that there is compulsion for a great many of us in certain areas of our way of life. For instance, if we wish to drive an automobile we are compelled to buy a licence for it; if we wish to continue as a member of a community we are compelled to pay our taxes. However, this is an entirely different situation where you will make somebody do something in which they have no choice. I do not have to drive an automobile, therefore, I do not have to buy

a licence.

We feel that voluntary organizations may well have accomplished all that the Ontario Hospital Services has accomplished. I point with some pride to the Windsor Medical Services which is a voluntary organization and it has in its district almost universal coverage for that area. I am not too sure that had we not been faced with a fait accompli of the Ontario Hospital Services private enterprise could not have produced a similar result, might have done it better or might have done it as well.

Then you come to the matter of compelling people from the standpoint of limiting their ability to choose the type of insurance that they want to take. Some people wanted to take out semi-private insurance, Blue Cross, and some wanted to take out public ward or standard ward and some would take on one type of insurance coverage and some another. Now, there are the same benefits, a standard benefit, which they are compelled to have.

This whole principle, we feel, is true in relation to all public health services. Medical health insurance, for instance, varies in its programs that are available to people. Some people want co-insurance, some people want full comprehensive insurance and we believe it is their right and choice.

Some people do not want it at all and we thing it is their right and choice. When we start to move to compelling people then it will almost - the compulsion would have to come from a central authority

I feel that a voluntary organization may well have to [illegible] that the Ontario Hospital Services has recommended. I [illegible] some areas of the [illegible] which is a voluntary organization then and it has an [illegible] maximum coverage for that area. [illegible] faced with a full [illegible] of the [illegible] hospital service or [illegible] could not have produced a similar result. [illegible] have done it better [illegible] might have done it as well.

When you come to the matter of compelling people from [illegible] in limiting their ability to choose the type of [illegible] that they wish to choose. Some people wanted to take out semi-private insurance, some [illegible], and some wanted to take out [illegible] or standard [illegible] on one type of insurance coverage and some on another. [illegible], there are [illegible] benefits, [illegible], which [illegible] to [illegible].

[illegible] principles, [illegible], is true [illegible] for instance, varies in its programme [illegible] people. Some people want co-insurance [illegible] comprehensive insurance and [illegible] choice.

[illegible] people do not [illegible] and [illegible] when we argue [illegible] to compel [illegible] when it is almost [illegible] from a central [illegible]

and this would have to be a Provincial or Dominion Government and if there is to be a compelling authority, there is control, a control would be exerted partly on the people who bought the insurance and partly on the people who provide the insurance for the services related to that insurance. I would include in that me and quite a number of the rest of us.

I feel I have a great stake in this democracy and so do the rest of the medical profession. We have a great stake in this country in which we want to live and I do not want to be compelled to accept a standard of care, a standard of income by my government. I want to feel right and free to choose the type of medical care that I want my patients to obtain; I want to be able to pick in every regard the consultants that they will have. Most of all, I do not want them to be compelled, in any way, to see me as a doctor or anybody else.

My feelings about compulsion, I think, are shared by all; that we are fundamentally opposed to any loss of freedom for any Canadian citizen.

COMMISSIONER FIRESTONE: I take it your objection to the Ontario Hospital program is that it is, to a significant extent, based on the principle of compulsion and only to a lesser extent on the question of voluntary participation? Am I correct in that understanding?

DR. BRUCE-LOCKHART: I think this is just one factor. I think that you have to take the other factors. You start off and say this is an insurance; we say it is a government program because it does have a

and this would have to be a federal or provincial board and if there is to be a compulsory authority, there is question, a control could be a mere party on the supply and weight the insurance and partly on the power to provide the insurance for the services rendered to that insurance. I would imagine in that is one quite a number of the ideas of me.

I feel I have a great stake in this democracy and so do the rest of the national organizations. We have a great stake in this country in which we want to live and I do not want to be compelled to accept a standard or say, a standard of income by my government. I want to feel rights and free to choose the type of medical care that I want by agreements to obtain, I want to be able to pick the money paying the consultants that my will have. Most of all, I do not want them to be compelled, in any way, to see me as a donor or provider.

My feelings about compulsion, I think, are summed up this, that we are fundamentally opposed to any loss of freedom for any Canadian citizen.

objection to the compulsory compulsory so that it is, a clear, that system, based on the principle of compulsion this only to a lesser extent in the question of compulsory [illegible]. As I answer in that understanding.

Mr. [illegible]: I think this is [illegible] factor. [illegible] that you have to take [illegible] factors. You start out and say this is an insurance, we say I do [illegible] proper [illegible] a

very considerable element of control. We see also that it has not avoided the thing I spoke of this morning which is in trying to solve one problem which was there at the time that the hospitals were going into debt and having difficulty and they were having difficulty because the indigent section of the population were paid for on a very minimal scale which nowhere near met the costs-- this was a problem and in trying to solve that problem they have created new ones, they have created the problem of - this is not a criticism of the O.H.S. Commission - where the hospitals have no means at present to liquidate their debt and this is thrust on the Commission by the regulations under Bill 320 through the Federal Government which stated "Only if you do thus and so may you have the money."

Now, there is a lot more to it than just the attitude of compulsion but we wanted to get on the record our attitude towards compulsion.

COMMISSIONER FIRESTONE: Do I understand from this that if the program were based on a fairly voluntary basis it would still not be acceptable to you because of the other sectors?

DR. BRUCE-LOCKHART: That is our point.

COMMISSIONER FIRESTONE: Thank you. Now, may I ask you to turn to page 298, paragraph 11? This paragraph 11 is one of the principles adopted by the Second General Assembly of the World Medical Association in 1948 and endorsed by the Council of the Ontario Medical Association in January, 1960. I take it from the fact that your Association has endorsed the principle it

[illegible]

very [illegible] [illegible] of control. We see also that it has not analysed the [illegible] of this training, which is in trying to solve the problem which we found at the time that the [illegible] were going into debt and having difficulty and were having difficulty securing the [illegible] acceptance of the acquisition were held for a very minimal [illegible] which nowhere near met the costs -- this was a [illegible] and in trying to solve that problem they have created new [illegible]. They have created a problem of - this is not a criticism of the U.S.S. [illegible] - [illegible] the [illegible] have no means at present to liquidate their debt and this is raised in the Commission by the recommendations under [illegible] through the [illegible] which [illegible] only if you do this and so may [illegible] the [illegible].

Now, there is a lot more to it than just the [illegible] of commission but we want to get on the record our [illegible] to [illegible] commission.

[illegible] FINNIGAN: [illegible] understand [illegible] the program were based on a family [illegible] [illegible] it will not be acceptable to you [illegible] of the other sections?

[illegible] MCDONALD: That is one point.

[illegible], may I ask you to turn to page 10, paragraph 11? This paragraph is in one of the [illegible] adopted by the [illegible] General Assembly of the World Meteorological Organization [illegible] by the [illegible], on the [illegible] [illegible] [illegible]. I take it from [illegible]

means that you are in favour of it. I would like to read that principle and ask you to explain it to me. I quote:

"Compulsory health insurance plans should cover only those persons who are unable to make their own arrangements for medical care."

Does that mean that you are in favour of compulsory health insurance plans for the indigent and the medically indigent?

DR. BRUCE-LOCKHART: I think the answer to that is no. I think you have to realize that when a World Medical Association adopts certain principles that one has to look at them in general and not necessarily look at them in detail. I think we would always take our view that our main and overriding principle is our own submission on compulsion which is on page 294.

You will see on page 295, paragraph 6(1):

"The medical profession as the provider of physicians' services must have the right and in the public interest, the responsibility to:

ensure that a high standard of medical services is maintained."

I think the remarks made by Dr. Galloway on our view of democracy, one and two, the remarks I made this morning which say that compulsion which prevents choice is wrong would be overriding. I think you have to acknowledge that some principles are perfectly right in their own text and you have to look at the other principles and combine the two on a particular problem.

COMMISSIONER FIRESTONE: Do I take it from this qualification that you are now stating that even if the set principle was endorsed by the Council of the Ontario Medical Association in 1960 that paragraph 11 is now not endorsed by your Association?

DR. BRUCE-LOCKHART: I think that you would have to interpret 11 also before you could make that comment exactly.

COMMISSIONER FIRESTONE: I would be happy to have your interpretation.

DR. BRUCE-LOCKHART: It depends on what you mean by voluntary. If we assume it would be voluntary for the citizens to pay taxes and out of those taxes you will provide care for health insurance plans for those individuals who paid, we have stated this is a proper role of government. If you are going to say that the individual must contribute, I cannot see how an individual can contribute voluntarily when he cannot make arrangements for his own medical care because these are indigents and he has not got the wherewithal to pay for medical care so I think this must be compulsory on the community for those who are unable to care for themselves.

COMMISSIONER FIRESTONE: Do I then understand that you endorse paragraph 11?

DR. BRUCE-LOCKHART: In that content.

COMMISSIONER FIRESTONE: A compulsory health insurance plan in the sense that the community as a whole will be paying their taxes and otherwise to the costs of medical care service provided to the indigent and medically-indigent in line with the recommendations you have made in this report?

DR. BRUCE-LOCKHART: That is right.

COMMISSIONER FIRESTONE: Therefore there are certain features of compulsion with which you are willing to live and other features of compulsion which you are not willing to accept?

DR. BRUCE-LOCKHART: Sir, some things are always with us, death and taxes.

COMMISSIONER FIRESTONE: Taxes are designed to preserve the provision of expanding and increasing health services to the people of Ontario. It is on this matter we are discussing the matter of compulsion.

DR. ATKINSON: Mr. Chairman, we wouldn't wish the Commission to go away thinking we would be happy if a plan were developed in which the conditions were such that by taxation or the payment of premium it would not be feasible for the average citizen to stay outside the plan. In other words, there would be compulsion because of the very nature of the plan itself. It wouldn't be compulsory in the sense that they had to, but the other inducements would make it almost impossible

for any person to stay outside the plan, and I think this wouldn't receive our support at all.

DR. LOCKHART: I think I should make one differentiation quite clear here, and that is this: That the medical profession, although I entirely agree with the general terms in which Dr. Galloway spoke, we agree that compulsion is necessary for the protection of the society. We don't think it is right that a man with smallpox should walk around and infect other people. There is the protection of the people. I think this is the proper role of government and the proper role anyplace.

COMMISSIONER FIRESTONE: I take it from what you are saying, talking about the development of a medical care plan or programme or programmes, that one basic principle that you want to see retained is the principle of voluntary participation?

DR. ATKINSON: That is correct.

DR. BRUCE-LOCKHART: And multiple choice.

COMMISSIONER FIRESTONE: Voluntary participation and multiple choice.

We have had put before us by the Province of Manitoba an appraisal, and I would like to put it before you, because in part it seems to follow some of the things you are saying and part of it, of course, goes in a somewhat different direction, and I would like to understand if a proposal of this order is in line with your thinking?

The Province of Manitoba emphasized like yourself the principle that such a plan, whatever

for any person to [illegible] the sign, and I think this wouldn't receive our support at all.

DR. [illegible]: I think I should make one differentiation quite clear here, and that is this: that in medical profession, although I can well agree with the general terms in which [illegible] voluntary approach, we agree that consultation is necessary for the protection of the society. We don't think it is right that a [illegible] to walk around and infect other persons. There is the protection of the people. I think this is the proper role of government and the [illegible]

CHAIRMAN [illegible]: I take it from what you are saying, in talking about the development of a medical care plan or programme or programmes, that the basic principle that you want to see retained is the principle of voluntary participation?

DR. [illegible]: That is correct.

DR. [illegible]: And multiple choice.

[illegible]

participation and multiple choice.

[illegible] have put before us by the [illegible] of the [illegible], and I would like to put it to you, because in part it seems to follow [illegible] you are saying, and part of it, of course, goes in a somewhat different direction, and I would like to have [illegible] a paragraph of this brief [illegible]

[illegible] province of Manitoba [illegible] the principle of the [illegible]

plan is developed or plans, should be voluntary. I think you have already said that it is an acceptable principle. The second principle that the Province of Manitoba suggested is that it should be universally available. Is that principle acceptable to you?

DR. SAWYER: Yes, sir.

COMMISSIONER FIRESTONE: The third principle that they suggested is that it should be a contributory plan with a stipulated premium within the range of the majority of the citizens of Manitoba. Would this be acceptable?

DR. SAWYER: Well, sir, I think when we get into discussing the submission of another Province that it would be desirable if we could have written questions relating to that submission which we may consider with the submission in front of us and give you a written reply. I think this would be fair.

COMMISSIONER FIRESTONE: Well, we want to be fair to you, and I am quite sure the secretary would be happy to make available to you a copy of the submission which we received.

At this point I wonder if you would consider the principle without getting involved in any of the details, and the principle I have raised is whether -- and I am putting it now in my own words rather than in the wording of the submission of the Manitoba Government -- how would you feel, sir, about a plan which may be developed by the Ontario Government on a voluntary basis where those who wished to participate would pay premiums if they were in a position to

plan is developed on plans, should be voluntary. I think you have already said that it is an acceptable principle. The second principle that the province of Manitoba suggested is that it should be universally available. Is that principle acceptable to you?

[illegible]

MR. [illegible]: Mr. Chairman, the point that they suggestion is that it should be a contributory plan with a stipulated premium within the range of the ability of the citizens of Manitoba. Would this be acceptable?

MR. SAWYER: Well, sir, I think when we get into considering the submission of another province that it would be desirable if we could have written questions relating to that submission which we may consider with the submission in front of us and give you a written reply. I think this would be fair.

MR. CHAIRMAN: INSTRUCTOR: Well, we want to be fair to you, and I am quite sure the secretary would be happy to make available to you a copy of the [illegible] which we received.

At this point, however, if you would consider the possible [illegible] without getting involved in any [illegible] details, the principle I have raised is [illegible] -- are getting it now in my own words rather than in the words of the submission of the Saskatchewan Government -- how would you feel, sir, about a plan which was developed by the Dominion Government [illegible] where those who wished to participate would pay premiums if they were in a position to

do so and those that were not in a position to pay the premiums would have those premiums paid for them by the State?

DR. SAWYER: Now, there are two or three things in your question, sir. I think you said a plan. Now, we have stated ---

THE CHAIRMAN: I think you would have to make it clear that was not the Manitoba proposal.

COMMISSIONER FIRESTONE: I have said I have restated this question in my own words.

THE CHAIRMAN: Maybe I didn't follow you all the way.

COMMISSIONER FIRESTONE: You requested a copy of the brief, and I was rewording the question in that light.

COMMISSIONER McCUTCHEON: You are wording your question not in connection with the Manitoba brief whatsoever.

DR. SAWYER: You said a plan, sir. Is that understood?

COMMISSIONER FIRESTONE: Yes.

DR. SAWYER: Then we have stated this morning on several occasions that we are not in favour of a single plan, we are in favour of multiple plans, multiple choice.

COMMISSIONER FIRESTONE: Assuming that this plan would not be an exclusive plan, it would be a plan permitting other plans to function as well.

DR. SAWYER: Is there only going to be one plan which is going to have participation by

to do and those that were not in a position to pay the premiums would have those premiums paid for them by the State?

DR. SAWYER: Now, there are two or three things in your question, sir. I think you said a tier. Now, we have stated ---

THE CHAIRMAN: I think you would have to make it clear that was not the Hamilton proposal.

COMMISSIONER FIRSTOWN: I have said I have restated this question in my own words.

THE CHAIRMAN: Maybe I didn't follow you all the way.

a copy of the brief, and I was rewording the question in that light.

working your question out in connection with the Hamilton brief whatsoever.

DR. SAWYER: You said a plan, sir, in that connection?

DR. SAWYER: Then we have stated this morning on several occasions that we are not in favour of a single plan, we are in favour of multiple plans, multiple choice.

(Commissioner Fitzpatrick: Assuming that that plan would not be a monopoly plan, it would be a plan permitting other plans to function as well.

DR. SAWYER: Is there only room to be the plan which is going to have jurisdiction in

government?

COMMISSIONER FIRESTONE: I presume you have recommended that the Provincial Government should look after the medical care services of the indigent and medically-indigent; presumably the Provincial Government, with or without federal contribution, would be making that contribution to the plan which the Commission administered. Assuming there was such a plan which the Provincial Government set up, it is a voluntary plan, it is a multiple plan, but it is a plan in which the Provincial Government would look after the sort of people you suggested should be looked after, the indigent and medically-indigent. Would you be in favour of such a plan?

DR. SAWYER: I am sorry, sir, but we have to be very careful with words and we have be most specific to understand exactly what you mean. We are not in favour of a single plan to which government would make contribution on behalf of the general population, and we have been quite clear, I think, in our submission that we feel those responsible should be able to look after themselves and we have made specific recommendations about the indigent and about the marginal income group. So I think it should not be difficult to know what our what our recommendations are in this particular area.

COMMISSIONER FIRESTONE: With all due respect, Dr. Sawyer-- and I am just trying to be helpful to come to the essence of the question -- my question relates to a provincial medical care plan.

DR. SAWYER: One?

government?

MR. [illegible] LIGHTOWLER: I presume you have recommended that the Provincial Government should look after the medical care services of the indigent and medically-indigent, presumably the Provincial Government, with or without federal contribution, would be making that contribution to the plan which the Commission administers. Assuming there was such a plan which the Provincial Government set up, is it a voluntary plan, is it a mandatory plan, or is it a plan in which the Provincial Government would look after the sick [illegible] people, or [illegible] should be looked after, the indigent and medically-indigent. Would you be in favour of such a plan?

DR. [illegible]: I am sorry, sir, but we have to be very careful with words and we have no most good in [illegible] exactly what you mean. We are not in favour of a single plan to which government would make contribution on behalf of the general population, and we have been quite clear, I think, in our submission that we see those responsible should be able to look after themselves and we have specific recommendations about the indigent and about the material income group so I think it would not be difficult to know what our [illegible] are in this particular area.

[illegible]: [illegible] I am [illegible] to be helpful to [illegible] -- my question relates to a provincial [illegible] plan.

[illegible]

COMMISSIONER FIRESTONE: One plan which permits a multiplicity of plans but with the Provincial Government looking for part of its area of coverage to look after the indigent and medically-indigent?

DR. SAWYER: And pays for their costs.

COMMISSIONER FIRESTONE: That is the plan I am talking about.

DR. SAWYER: You are talking about the welfare plan we have now?

COMMISSIONER FIRESTONE: No.

DR. SAWYER: An enlargement of it?

COMMISSIONER FIRESTONE: I am talking about a provincial medical care plan which would provide care for (a) the indigent and medically-indigent, which would provide to anyone wishing to have insurance coverage.

COMMISSIONER McCUTCHEON: Dr. Sawyer has said he is opposed to any plan to assist the people who can pay for themselves.

COMMISSIONER FIRESTONE: My questions don't deal with the subject the Commissioner talks about. There is no tax question as far as the non-indigent and non-medically-indigent are concerned. We are talking about one feature of the plan which provides for the indigent, medically-indigent and provides an insurance coverage for those who wish to participate.

DR.SAWYER: You said one plan and one administration?

COMMISSIONER FIRESTONE: Correct, sir.

COMMISSIONER TRUSSION: One plan

which permits a public hospital to turn out with the provincial government looking for part of its area of coverage to look after the indigent and medically-

MR. AWLEY: And pays for their care.

COMMISSIONER TRUSSION: That is the plan I am talking about.

MR. AWLEY: You are talking about the medicare plan we have now?

MR. BOWER: An enlargement of it?

COMMISSIONER TRUSSION: I am talking about a provincial medical care plan which would provide for (a) the indigent and medically-indigent, which would provide to citizens wishing to have insurance coverage.

MR. BOWER: Is opposed to my plan to assist the people who can pay for themselves.

COMMISSIONER TRUSSION: My questions don't deal with the problem the Commissioner talks about. There is no protection as far as the non-indigent and medically-indigent are concerned. He is talking about the people of the province, providing for their care, medical care and provides an insurance connection for those who can't afford it.

MR. AWLEY: You have one plan and

COMMISSIONER TRUSSION: Correct, sir.

DR. SAWYER: We would be opposed, as we have stated, to anything in this area where there was one plan and one administration or one controlling administration.

COMMISSIONER FIRESTONE: Even though such a plan would permit multiplicity of other plans? How would you be able to operate a government plan which says we have a plan, if you want to participate in this plan you can, if you want to participate in another plan you can? What is the objection to that if the principle of multiplicity is retained?

DR. SAWYER: Why would you need a government plan if you have a multiplicity of plans in the same area? How would it be different or for what reason are we discussing the necessity of a government plan which would do exactly the same as other plans? I want to get this clear.

COMMISSIONER FIRESTONE: The answer is that there were some demands forthcoming from recipients of medical care service for a government-sponsored medical care plan, and I am just trying to find out if there was any formula or any aspect of meeting such requests that were put before us which would be acceptable to the medical profession of Ontario. If the answer is no such plan is acceptable to you in any form, then all you have to say is no.

DR. GALLOWAY: Would this plan that you have mentioned have fiscal autonomy?

COMMISSIONER FIRESTONE: I would like you to elaborate your definition of "fiscal autonomy".

Mr. BARRETT: He would be opposed, as we have stated, to anything in this area where there was one plan and one administration or one controlling administration.

Such a plan would permit multiplicity or other plans? How would you be able to operate a government plan which says we have a plan, if you want to participate in this plan you can, if you want to participate in another plan you may. What is the objection to that if the principle of multiplicity is retained?

Mr. MAYER: Why would you need a government plan if you have a multiplicity of plans in the same area? How would it be different to say what reason are we discussing the necessity of a government plan which would do exactly the same as other plans? I want to put this aside.

It is that there were some demands from many from residents of medical care service for a government-sponsored medical care plan, and I am just trying to find out if there was any formula or any aspect of meeting such requests that were put before us which would be acceptable to the medical profession or therefore, if the answer is no, such plan is acceptable to you in any case, then all you have to say is no.

Mr. MARTIN: Does this plan that you have mentioned have legal autonomy?

Mr. [illegible]: I would like you to elaborate your interpretation of legal autonomy.

DR. GALLOWAY: Yes. Would the money coming from premiums be used entirely to support this plan and with no government money?

COMMISSIONER FIRESTONE: The plan would have to include payments from governments to cover medical care for the indigent and medically-indigent, and therefore it will be financed partly from taxes and partly from premiums.

DR. SAWYER: Mr. Chairman, I am sorry that we have arrived at a position where it seems difficult to answer the questions which are being put, and I think the reason for this is it is very difficult to pinpoint exactly what we are talking about, and I would like to go back to the suggestion that I made earlier, that if the Commission is interested in this field we would be happy to receive your written questions so that we could consider them and give you in turn our considered opinion, so that we would have in front of us the benefits, we would have in front of us how the money is to be derived, we would have in front of us the administration, we would have in front of us the relationship to other plans, its fiscal autonomy and many other things on which we would want to have specific information to answer this line of questioning, if that would be agreeable, Mr. Chairman.

COMMISSIONER FIRESTONE: Dr. Sawyer --

THE CHAIRMAN: Now, the question is addressed, I take it, to me, Dr. Sawyer?

DR. SAWYER: Yes.

DR. BRUCE-LOCKHART: I think we are in

[illegible]

Mr. CARLISLE: [illegible] would the money [illegible] be used [illegible] to support the [illegible]

[illegible]

would come in income payments from governments to cover the local care for the indigent and mentally-ill people, and therefore it will be financed partly from taxes and partly from payments.

Mr. [illegible]: Mr. Chairman, I am sorry that we have arrived at a position where it seems difficult to answer the questions which are being put, and I think the reason for this is it is very difficult to phrase exactly what we are talking about, and I would like to go back to the suggestion that I made earlier, that if the Commission is interested in this [illegible], we would be happy to receive your written questions and we could consider them, and give you in turn our considered opinion, so that we would have in front of us the [illegible] to be [illegible], we would have in front of us the [illegible] transition, we would be in a position to give us the [illegible] relationship between the federal authority and the provinces as which we would seem to have [illegible] in relation to answer this type of question, [illegible] be [illegible], Mr. Chairman.

Mr. [illegible]: Now, one question in addition, I see it, to me, [illegible]

[illegible]

[illegible] I [illegible] to

an area of difficulty, Mr. Chairman, and if you feel you can't answer Dr. Sawyer's question I think that would be fine. I think the problem really is that the Commissioner is asking a question in very, very broad terms, and in very, very broad terms it is a difficult question to answer precisely.

an area of difficulty, Mr. Chairman, and if you feel you can't answer Mr. Sawyer's question I think that would be fine. I think the problem really is that the Commissioner is asking a question in very, very broad terms, and in very, very broad terms it is a difficult question to answer precisely.

We are frankly afraid if we say bluntly no someone could produce facts and figures of a plan that could suit us. If we say yes, equally we could disapprove very much for many good reasons. These are the areas of difficulty. We were asked a very broad general principle, and I answer in an equally broad way - we could give you a broad term answer now, we could say what I said this morning, if it doesn't intefere with the doctor-patient relationship, if it doesn't exert any control, if it doesn't interfere with multiplicity of choice, then very likely we would be quite happy.

I find it extremely difficult to envisage such a situation. I think that is the answer in very general terms. Also, I have one other point, Dr. Galloway reminds me; we said we are doubtful about the word insurance in relation to governments because in experience it is true, in the history of the world, it is very rarely a purely insurance principle. That is where we have the difficulty in giving you an honest answer to that question. We are trying to be honest, but it is difficult to give you an answer to that.

THE CHAIRMAN: Any answer that you gave, to be of any help to us would have to be a considered answer. I think the request is reasonable.

COMMISSIONER FIRESTONE: I quite concur, Mr. Chairman, the request is very reasonable. For myself I would accept Dr. Bruce-Lockhart's general answer as an answer. He is quite right this was a general question and the way to deal with it is in a general manner. As I understand it the Ontario Medical Association has an

[illegible]

[illegible] I think it is an identity
to someone could produce facts and figures of a plan
that could exist now. If we try very, really to could
discover very much from many good reasons. These are
the areas of difficulty. In were asked a very broad
general principle, and I answer in an equally broad way -
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what I said this morning, it is doesn't interfere with the
doctor-patient relationship, if it doesn't cause any
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service, then very likely we would be quite happy.

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[illegible]

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is very rarely a purely insurance method. That is
where we have the difficulty in giving you an honest
answer to that question. We are trying to be honest,
but it is difficult to give you an answer to that.

[illegible] I think that you are
to be commended. It is a privilege to be a consultee
[illegible]. I think the argument is [illegible].

[illegible] I [illegible] question,
in [illegible], the [illegible] is very reasonable. For myself
I was [illegible] to. [illegible] general [illegible]
[illegible] is quite [illegible] was a general question
and [illegible] a [illegible] is in - [illegible] [illegible]
[illegible] it [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

open mind on the subject and will look at such a proposal with an open mind. Its mind is not closed. That is the essence of the general answer.

DR. BRUCE-LOCKHART: The essence is as we said this morning, what we believe, and that would have to apply to any plan we saw. We wouldn't close our minds completely in looking at any plan except we don't wish to have one; we want a multiplicity of choice.

COMMISSIONER FIRESTONE: Thank you very much. Could we turn to paragraph 235 on page 70 and I quote:

> "We have reached a stage in our province where the majority of our citizens have insured themselves against all or part of the cost of medical services."

Dr. Sawyer, would you be able to define what you mean, or your Associations means, by all medical services? Does that cover services of the physician or does that cover services of para-medical personnel, drugs, etc.?

DR. SAWYER: Dr. Atkinson?

DR. ATKINSON: When we refer to medical services we refer to the personal services provided by the physician.

COMMISSIONER FIRESTONE: I also see in the same paragraph that there is insurance in existence against all or part of the cost of medical services. When you speak of all services is that all services in the sense that the patient doesn't have to pay anything extra for medical services received? Is that what "all" means?

on a mind on the subject can will soon at such a process with an open mind. [illegible] is not closed. That is the essence of the general answer.

We said this morning, and we believe, the first would have to go [illegible] any plan we [illegible]. In [illegible] closer, [illegible] completely [illegible] looking at any plan except we don't wish to have [illegible] we want a multiplicity [illegible] choice.

Much. Could we turn to paragraph 265 on page 6 and I quote:

"We have reached a stage in our province where the majority of our citizens have insured themselves against all or any of the cost of medical services."

Mr. Speaker, would you be able to define what this means, or your recommendations means, or all medical services? Does that cover services of the physician or does the [illegible] include [illegible] insured, drugs, etc.?

[illegible] Mr. Speaker?

A. LEVEQUE: When we mean a medical service we mean [illegible] by the [illegible].

[illegible] I also see in [illegible] that there is [illegible] in existence [illegible] the [illegible] of medical services. Now, [illegible] of all [illegible] is that, I [illegible] in the [illegible] [illegible] to [illegible] the [illegible] "[illegible]"

DR. ATKINSON: Yes, Mr. Chairman; in answer to that, the answer is yes, bearing in mind that approximately 50% of the coverage available is made available to the people of the province through doctor-sponsored plans and this mechanism, in many instances, assures the patient there is no additional cost. This again is a very difficult thing to analyze and to bring forth figures that are meaningful and we are not in a position to provide this information.

COMMISSIONER FIRESTONE: Would it be possible at some subsequent time, not on this occasion, to provide us with information of the ratio of what you define as medical services and what you call part of the cost of medical services? After all, you say 63% are covered in surgical cases and 59% against medical. Some of these have all their costs covered and some of these have only part of the cost. The ratio is rather important because those that only have part coverage may find it very difficult to meet the extra billing. We would like to know a little bit more about that if such information is available.

DR. GALLOWAY: May I ask a question of you, Commissioner Firestone, or make a statement - one of the advantages of the multiplicity of plans is the great choice that people have. There are some people who don't wish to have all of their medical expenses covered. This would require our going to all the Canadian or Ontario insurance industries. It is a right of choice of a great number of people. I don't believe that we could really accede to your request because I don't know how we

would find this.

DR. BRUCE-LOCKHART: We could certainly try. I think it would be very difficult. I don't think with the amount of work involved and the time - I would think you would need some answers shortly; I don't think we are hopeful we could do it.

COMMISSIONER FIRESTONE: Could I leave it to your good judgment; if this information is more or less readily available it will be given to us and if it isn't, you will just notify our Secretary that it was difficult for this or that reason?

DR. BRUCE-LOCKHART: We would be happy to do this.

COMMISSIONER FIRESTONE: May I go back to one paragraph? It is paragraph 231, where you make reference to prepaid hospital and medical services. I quote:

> "The Act, as interpreted to us by the Superintendent of Insurance, allows all non-profit plans which pay the majority of accounts directly to the physicians, to operate under the Act."

Do you approve of the principle of these voluntary non-profit plans paying the medical fees directly to the physicians?

DR. SAWYER: Dr. Bruce-Lockhart?

DR. BRUCE-LOCKHART: This was looked at by a Committee of our Association some three years ago and, in general, the Committee said that the principle of dealing directly with your patient was the best one. At

would find this.

tev. I think it would be very difficult. I don't think with the amount of work involved and the time - I would think you would need some answers shortly; I don't think we are hopeful we could do it.

it to your good judgment; if this information is more or less readily available it will be given to us and if it isn't, you will just notify our Secretary that it was difficult for this or that reason?

Mr. [illegible]-LOCHLAKT: We would be happy to do this.

CHAIRMAN [illegible]: May I go back to the paragraph? It is paragraph 281, where you make reference to prepaid hospital and medical services. I quote:

"The act, as interpreted to us by the Department of Insurance, allows all non-profit plans which by the majority of accounts directly to the physicians, to operate under the Act."

Do you approve of this practice of these voluntary non-profit plans paying the medical fees directly to the physicians?

Mr. [illegible]: This was looked at

the same time it didn't deny the right of any doctor as an individual and a free agent to be paid that way if he so chose. We have to acknowledge that the costs of administration are involved in this and we, therefore, have to accept that in some situations this may be reasonable, although the general principle was the one stated. I don't know whether any of the others would like to answer further. Dr. Galloway, would you like to say any more to that?

DR. GALLOWAY: I think you have answered it.

COMMISSIONER FIRESTONE: Would you feel that the direct payment of a group, say, like P.S.I., to these participating physicians, would in any way affect the quality of medical service provided by the participating physician?

DR. BRUCE-LOCKHART: As far as Physicians' Services Incorporated is concerned, it is run by the doctors. It is sponsored by the doctors, started by the doctors. To talk jargon for the moment, it is our baby, and we do our best to support it and have always done so. I think this is correct. That is why the majority of doctors do accept such payment, but not, by any means, all. We wouldn't wish, in any way, to force them to do so.

COMMISSIONER FIRESTONE: You have made quite clear the voluntary principle, and we understand it. To come back to the question, if I may; is the fact that P.S.I. pays the bills of the participating physicians directly, to your knowledge or the knowledge of your

the same time it wasn't very the right of any doctor as an individual and a free agent to be said that way if he so chose. We have to acknowledge that the costs of administration are involved in this and we, therefore, have to accept the [illegible] situations this may be reasonable. Although the general principle was the one stated, I don't know whether any of the witness would like to answer further. Dr. Galloway, would you like to say any more to that?

DR. GALLOWAY: I think you have answered

COMMISSIONER HEASLOCKER: Would you feel that the direct payment of a group, say, like P.S.I., to these practice-time payment is, would in any way affect the quality of medical service provided by the practicing physicians?

DR. HOUSE-LOCKHART: As far as physicians services incorporated in a measure, it is run by the doctors. It is sponsored by the doctors, staffed by the doctors. To talk jargon for the moment, it is self-help, and we do our best to support it and have always done so. I think this is correct. That is why the majority of doctors do accept such payment, but not, by any means, all. We wouldn't wish, in any way, to force them to do

[illegible] clear the voluntary principle, and we understand it.

colleagues, in any way affecting the quality of services, medical services, which participating physicians render to their patients?

DR. BRUCE-LOCKHART: I don't think so, sir.

COMMISSIONER FIRESTONE: Thank you very much. That is very helpful.

DR. GALLOWAY: Providing, sir, as I am sure Dr. Bruce-Lockhart meant, it is a situation where there is doctor control over the amount that will be paid; in other words, there is no control through some other authority.

COMMISSIONER FIRESTONE: The question was posed in the context of P.S.I. and I think Dr. Bruce-Lockhart had that in mind. Am I right?

DR. BRUCE-LOCKHART: Quite right, sir.

COMMISSIONER FIRESTONE: Perhaps, and I address this question to you, Dr. Sawyer, and again, please refer to any of your colleagues: I am sure you are familiar with the discussion that took place in the Legislature of Ontario on March 26th, 1962, in which the claim was made that there are a number of practising physicians in the Province of Ontario that sell their medical accounts to collection agencies at a discount of 14%. Has your Association had an opportunity of looking into this question of the alleged complaint?

DR. SAWYER: All I want to say is this was brought to the attention of our Association and was examined by our Committee on Ethics and the Committee on Ethics gave the opinion that this was probably an unwise

colleagues, in any way affecting the quality or services, medical services, which particularly unfortunate reason to their patients?

sir.

much. That is very helpful.

DR. MALDONADO: Provided, sir, as I understand Dr. Bruce-Lockhart meant, it is a situation where there is doctor control over the amount that will be paid; in other words, there is no control through some other authority.

was posed in the context of P&I, and I think Dr. Bruce-Lockhart has that in mind. Am I right?

DR. BRUCE-LOCKHART: Quite right, sir.

CHAIRMAN'S DIRECTION: Perhaps, and I address this question to your Honour-Lawyer, and again, please refer to any of your colleagues. I am sure you are familiar with the discussion that took place in the Legislature on Ontario on March 29th, 1966, in which the medical profession to collection agencies or a discount or 10%. Was your Association had an opportunity of looking into this question of the alleged conflict?

DR. MARTIN: All I want to say in this was formally to the question of our Association and the Ontario Medical Association and the committee on Ontario gave the opinion that this was probably an unwise

thing for doctors to do, and referred the matter to the College of Physicians and Surgeons which has responsibility under the Medical Act to look at such matters. I believe that the College has met and is about to issue a statement about it, sir.

COMMISSIONER FIRESTONE: Have you looked into the question of how widespread this practice is in Ontario?

DR. BRUCE-LOCKHART: I believe at least 100 doctors, sir.

COMMISSIONER FIRESTONE: Is that number growing?

DR. BRUCE-LOCKHART: Not now, sir, no.

COMMISSIONER FIRESTONE: I am happy to have that answer. Would you say that such a practice would affect a doctor-patient relationship?

DR. SAWYER: Yes, I think it could, sir. I think it could because if the first bill the patient received was from some organization other than the doctor I think it would make it more difficult to arrange with the doctor about complaints you might have had either about services or the amount of the bill or various other matters.

COMMISSIONER FIRESTONE: Thank you very much for the explanation. May we turn now to paragraph 239 on page 71 and I quote:

"At the present time there are nearly 40 non-profit plans operating under the Prepaid Hospital and Medical Services Act; there are many plans

thing for doctors to do, and referred the matter to the College of Physicians and Surgeons which has responsibility under the Medical Act to look at such matters. I believe that the College has met and is about to issue a statement [illegible].

[illegible] into the question of how widespread this practice is in Ontario?

DR. [illegible]: I believe at least 100 doctors, sir.

COMMISSIONER [illegible]: Is that number growing?

DR. [illegible]: Not now, sir, no.

COMMISSIONER [illegible]: I am happy to have that answer. Would you say that such a practice would affect a doctor-patient relationship?

DR. [illegible]: [illegible] I think it could because if the first [illegible] received was from some organization other than the doctor I think it would make it more difficult to discuss with the doctor about complaints you might have had, either about services or the amount of the bill or various other matters.

[illegible] then the explanation. May we turn now to [illegible] on page 7? and I quote:

> "At the present time there are [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] there are many [illegible]

underwritten by indemnity companies, some of which are stock companies and some mutual; in addition, there are a number of plans which limit coverage to a class of citizen or a type of illness."

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Would you say there are more plans of the second category, there are those underwritten by indemnity companies, and those mentioned in this paragraph, than there are non-profit plans operating in the Province of Ontario?

DR. SAWYER: You mean in numbers sir?

COMMISSIONER FIRESTONE: Yes.

DR. SAWYER: Yes.

COMMISSIONER FIRESTONE: Considerably more?

DR. SAWYER: Dr. Atkinson, you might be able to answer it.

DR. ATKINSON: Mr. Chairman, as indicated there are approximately 40 plans under the Provincial Act. The Canadian Health Insurance Association, which will be making a submission to the Commission at a later date, has a membership of some 114 or 15 members, and these men all sell coverage in this Province, but I think it would be important to realize that a large percentage of them, we also understand, dealing with the coverage -- without going back to the question that you mentioned earlier -- that 50% of those having coverage have it in the prepaid plan and 50% having coverage have it under the other carriers. This is a plus or minus figure. Approximate ratio.

COMMISSIONER FIRESTONE: I take it from what you are saying that there are something like between 100 to 150 plans, different types of voluntary and commercial in operation in the Province. Would that be the range?

Could you say there are more plans of the second category, there are those underwritten by indemnity companies, and those mentioned in this paragraph, then there are non-profit plans operating in the Province of Ontario?

DR. SAWYER: You mean in numbers sir?

DR. SAWYER: Yes.

COMMISSIONER FISHER: Immediately

[illegible]?

DR. SAWYER: Dr. Atkinson, you might be able to answer it.

DR. ATKINSON: Mr. Chairman, as indicated there are approximately 40 plans under the Provincial Act. The Canadian Health Insurance Association, which will be making a submission to the commission at a later date, has a membership of some 14 or 15 members, and these men all sell coverage in this Province, but I think it would be important to realize that a large percentage of them, we also understand, sell the coverage -- without going back to the question that you mentioned earlier -- that 50% of those having coverage have it in the prepaid plan and 50% having coverage have it under the other carriers. This is a pure or minus figure. Approximate is it.

COMMISSIONER FISHER: I take it from what you are saying that there are some kind of overlap in the plans, different types of voluntary and commercial in operation in the Province. Is that the range?

DR. SAWYER: I would think so, yes.

COMMISSIONER FIRESTONE: You are in favour of multiplicity. Do you really feel that you need multiplicity of the order of 100 to 150 plans to take care of medical care services of the people of Ontario?

THE CHAIRMAN: I think to be of help, Dr. Sawyer's answer, I think you must accept it as the doctor's answer in the field that he is not informed. There may be 150 companies writing business but it doesn't mean 150 plans. They may all be writing the same plan, or virtually the same plan so that it may be five or six basic plans written by 150 carriers.

Now if you want to have the question meaningful at all, it would have to be in that context.

COMMISSIONER FIRESTONE: I think Mr. Chairman, it is very useful and I am very much obliged to you for your interpretation. What I had in mind in asking you this question, Dr. Sawyer, is that we have somewhere between 100 to 150 various agencies, close to 40 are of the non-profit type plan and 100 are more or less of the commercial type and they all have different plans.

THE CHAIRMAN: No, that is not right, that is the very thing I said they did not have. I am telling you they have perhaps five or six. If you don't want to accept it, you don't accept it and we go on, but they haven't got 150, and it's just nonsense to say so.

COMMISSONER FIRESTONE: My question to

Dr. LAWYER: I would think so, yes.

COMMISSIONER FASTNER: You are in favor of multiplicity. Do you really feel that you need multiplicity of the order of 180 to 190 plans to take care of medical care services of the people of Ontario?

Dr. CHARNAK: I think to be of help, Dr. Lawyer's answer, I think you must accept it as the doctor's answer in the fund that he is not informed. There may be 180 companies writing business but it doesn't mean 180 plans. They may all be writing the same plan, or virtually the same plan so that it may be five or six basic plans written by 180 carriers.

Now if you want to have the greater meaningful to all, it would have to be in that content.

COMMISSIONER FASTNER: I think, Chairman, it is very useful and I am very much obliged to you for your interpretation. When I am in mind in asking you this question, Dr. Lawyer, is that we have somewhere between 150 to 180 various companies, those to do any of this non profit type plan and 150 are more or less of the commercial type and they all have different plans.

Dr. LAWYER: No, that is not right. That is the very thing I said they did not have. I am telling you they have perhaps five or six. If you don't want to accept it, you don't accept it and go on, but they haven't got 180, that is the nonsense to say so.

COMMISSIONER FASTNER: My question to

Dr. Sawyer refers to -- if I may explain my question -- it refers to the various organizations that are of the order of 100 to 150. They may have five plans operating. They may have 15 plans. They may have 25 and the facts, if you wish to get them, will get them from the organizations themselves. My question to you is, as representative of the medical profession, do you feel that your definition or your concept of multiplicity requires that there would be 150 or 100 companies, of that range of companies, operating in the Province of Ontario to provide these services, and particularly do you feel that you need close to 40 non-profit plans to provide efficient and comprehensive coverage of the form of medical care insurance to the people of Ontario or could you visualize a situation whereby this number could be greatly reduced by an amalgamation of a number of plans, or, to follow the Chairman's wishes, a number of organizations?

THE CHAIRMAN: I have no wishes at all.

COMMISSIONER FIRESTONE: Your interpretation.

DR. SAWYER: Well, Mr. Chairman, if I might start this answer to this question by dealing with the part that you referred to, in particular the 40 prepaid plans. I think its very function in this Province --- these plans have grown up for particular reasons.

We have P.S.I. We have Windsor Medical. We have Associated Medical Services which are perhaps the larger plans but then you have a plan

Dr. LAWYER refers to -- if I may explain my question -- it refers to the various organizations that are of the order of 100 to 150. They may have five plans operating. They may have 15 plans. They may have 25 and the facts. If you wish to get them, will get them from the organizations themselves. My question to you is, as representative of the medical profession, do you feel that your definition or your concept of multilateral requires that there would be 100 or 150 companies, or that type of companies, operating in the Province of Ontario to provide these services, and particularly do you feel that you need those to be non-profit plans to provide efficient and comprehensive coverage of the form of medical care insurance to the people of Ontario or could you visualize a situation whereby two number could be primarily provided by an sub-division of a number of plans, or, as Mr. Chairman's wording, a number of organizations.

Dr. [illegible]: I have to disagree.

Mr. [illegible]: Your interest.

Dr. [illegible]: Well, Mr. Chairman, if I might start the answer to this question by dealing with the part that you referred to -- articulation the co-ordinated plans. There is a very [illegible] in this province -- I know plans have grown up for [illegible]

[illegible]

[illegible] medical. We have been [illegible] which the [illegible] have [illegible] have a plan

like the Co-operative plans which are on a county basis and these plans devote their energy to developing means of enrolling the farm populations of this Province.

There is another one that devotes itself to unions, through a credit union movement, and there are many other examples of how they started, for a particular purpose.

Now it might be a question of whether they should be amalgamated, but I think the need arises, when you amalgamate these plans, that no longer do you have a specific group of people interested in the development of specific plans for the people that they know best.

Now when you come to the indemnity companies, these companies, of course, are licensed by the superintendent of insurance and I would think it must be his feeling to grant this number of licences; that it is in the public interest and I would not want to be drawn into a discussion where we would get down to determining the exact number of companies that we think is required. I think we have stated that we want enough companies that people can have multiple choice, as they see fit.

COMMISSIONER FIRESTONE: Would you feel that perhaps with a possible reduction or a combination of some of these plans -- and I am using, Mr. Chairman, the wording of paragraph 239. Just for the record, I would like to read this wording because I am using it in the context of the submission by the Ontario Medical Association:

"At the present time there are nearly
"40 non-profit plans operating under
"the Prepaid Hospital and Medical
"Services Act."

My question relates exactly to the wording that you have used.

Would you feel that if there were a simplification of such plans, and fewer agencies administering such plans that this may provide more efficient services on health insurance to the people of the Province of Ontario?

DR. BRUCE-LOCKHART: I think I would like to answer that. I think the answer is we believe under the evolutionary process, if this were to be true, it would occur; that if under the evolutionary process, what Dr. Sawyer mentioned which was that these small plans can better cater to a local problem in a local community, then they will persist, and I think this would be our answer as an Association.

THE CHAIRMAN: You are using the word "plan" to mean both the means by which the coverage is defined and the organization?

DR. BRUCE-LOCKHART: Yes. I was using it in the context of this particular paragraph.

THE CHAIRMAN: In the context of the plan here you are talking about the organization or the method?

DR. BRUCE-LOCKHART: Yes. In this particular context we were talking about the number and variety of insurance.

THE CHAIRMAN: The organization. They may all be insuring according to the same plan?

DR. BRUCE-LOCKHART: They might be.

THE CHAIRMAN: The Co-ops are basically the same.

DR. BRUCE-LOCKHART: Very much. Very similar, yes.

COMMISSIONER FIRESTONE: My last question relates to page 297, paragraph 9, and I quote:

"Remuneration of medical services "ought not to depend directly on the "financial condition of the insurance "organization."

Again, this is a principle which has been adopted by the Second General Assembly of the World Medical Association, 1948 and endorsed by your Council.

I wonder if you were to apply this principle to the situation in Ontario how you could explain to us what this principle means?

DR. BRUCE-LOCKHART: I think what is meant by that there is that in medical care you are dealing, at the present time, with a personal contract between the physician and his patient. Now the insurance is another problem. It's outside this. It's a matter that the patient undertakes to insure himself with an agency.

Now this is a thing that the patient does but the relationship and the remuneration outside that and agreed upon between the patient and the doctor, it may be, if anything, from nothing up to whatever figure is appropriate. That is a matter between the

patient and the doctor and the insuring agency should not say how much the doctor may or may not require for a particular service. I think this is as clear as I can make it.

COMMISSIONER McCUTCHEON: You mean if the Great West Life loses money, the doctor should not lose money?

DR. BRUCE-LOCKHART: It has nothing to do with the doctor's contract between him and the patient.

THE CHAIRMAN: Financial condition of the company?

DR. BRUCE-LOCKHART: No.

COMMISSIONER FIRESTONE: You expressed the fear, when you spoke about total or major government financing, Dr. Bruce-Lockhart, that one worry you would have is that monies for medical care would have to compete with other needs, and that political expediency would be the determing factor rather than the requirements of such a program.

If adequate safeguards were provided to the satisfaction of the medical profession would you still feel that this objection would hold? In other words, there were certain amounts assigned and guaranteed for that purpose.

DR. BRUCE-LOCKHART: Well sir, I think you would have to answer that perhaps in the context of history. It's very difficult for the medical profession to view adequate guarantees. After all in a democracy, and this is right, that no Government can bind the next

patient and the doctor and the insuring agency which
not say how much the doctor may or may not charge
for a particular service. I think this is as clear as
I can make it.

COMMISSIONER WEINTRAUB: You mean if
the court must life issues money, the doctor should not
[illegible]

DR. DAVID LOCKMAN: It has nothing
to do with the doctor's contract between him and the
patient.

MR. GERSHAW: Financial connection of
the company?

DR. DAVID LOCKMAN: No.

COMMISSIONER WEINTRAUB: Let examples of
the case, when you speak about fees or some government
financing, do some doubt, that one entity you could
have is that medical fee-related case would come to
court, directly, maybe, not that court can exercise
would be the determining factor rather than the requirements
made in such a program.

In order to avoid misunderstanding
to the administration of the medical profession would you
state that this operation would not. In other
words, these were certain amounts agreed guaranteed
for that purpose.

DR. DAVID LOCKMAN: Well say, I think
you would have to answer that in the context of
[illegible] It's very difficult for the medical profession
to view [illegible] [illegible] in a monopoly,
[illegible]

Government, particularly if it happens to be a different party. I think this situation has worked quite well in Australia, for example, sir, because in their written constitution there is a safeguard, namely, that you may not conscript any segment of the population in time of peace.

It's very difficult to envisage for us a situation where the safeguard could be built in sufficiently to prevent the next Government repudiating it completely and I think that you would be aware of the Spencer Committee Report in Great Britain, and so on. We don't need to go into that.

COMMISSIONER FIRESTONE: I take it that what you are saying is that your objection is not so much against the principle but the application of the principle because you fear that while you may have reached an understanding with one government, that understanding may not hold in the future. It's because of that concern that you would prefer for Ontario to continue with the present system in a process of evolution?

DR. BRUCE-LOCKHART: It's one factor, sir, yes.

COMMISSIONER FIRESTONE: Thank you very much.

THE CHAIRMAN: Dr. Van Wart?

COMMISSIONER VAN WART: Mr. Chairman, the criticism has been made that the voluntary plans do not supervise the type of care given by their participating doctors. Have you any comments to make on that criticism?

government, particularly if it happens to be a different party. I think this [illegible] has [illegible] quite well in Australia, for example, [illegible], because in that [illegible] constitution there is a [illegible], namely, that you may not [illegible] any [illegible] of the population in time of peace.

It's very difficult to [illegible] on as a situation where the safeguard could be built in [illegible] to prevent the most [illegible] recognition, it's [illegible] and I think that you [illegible] aware of the Jurisdiction Committee's report in [illegible] Parliament, and so on. [illegible] that.

[illegible] I take it that what you are saying is that your objection is not so much against the principle but the [illegible] of the principle [illegible] you feel that [illegible] may have [illegible] an [illegible], with the [illegible], that [illegible], may [illegible] in the future. It's [illegible] or that [illegible] would [illegible] continue [illegible] the present system [illegible] [illegible].

Mr. BIRD: [illegible] [illegible] one [illegible], [illegible], [illegible].

[illegible] [illegible] [illegible] very much.

[illegible] [illegible] [illegible]

The criticism has been made that the [illegible] [illegible] not [illegible] the [illegible] given by their [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

DR. ATKINSON: Dr. Van Wart, may I ask you to repeat your question?

DR. SAWYER: The question of supervision of medical care by the prepaid medical plan, as I understand it.

COMMISSIONER VAN WART: The type of care given by the participating doctors have no supervision. That citicism has been made of the voluntary plan.

DR. ATKINSON: Mr. Chairman, I think it would be fair to comment that in our opinion the regulation of a doctor should be carried on within his own community and I think that the doctors are very conscious of their responsibility to the doctor-sponsored plans.

We have established a Medical Advisory Committee within P.S.I. made up of members of the profession on the recommendation of the doctor and this looks at particular problems. The Board of Directors of Physcian Services Incorporated are, in the main, physicians and we have close liaison between the Board of Governors of that organization and the Board of Directors of the Ontario Medical Association and these problems would be brought inevitably. As in any other profession, in any other group of citizens you find those who make it difficult for the great majority of that group to get along and I think this problem of control is only necessary in a very, very small percentage of cases and we, in the Medical Association, have established mediation committees to do just this thing,

involving the responsible people, those who have received these services and those who have given these services, sitting down in a mediatory fashion and come to an understanding. This is a voluntary process which in our way of life we feel is a satisfactory one and that you cannot legislate satisfactorily in a blanket fashion.

DR. BRUCE-LOCKHART: If I can make a comment on that -- would I be permitted sir?

THE CHAIRMAN: Yes.

DR. BRUCE-LOCKHART: I think that we have to divide the question in two halves and really the question is, what Dr. Atkinson was talking about, is control of abuses of the plan.

COMMISSIONER VAN WART: I did not mean that.

DR. BRUCE-LOCKHART: If you are talking about the control of the quality of the service of the physician, this is not the business of insurance. This is the business of the medical profession and we tackle this in various ways and we are constantly cognizant of it. We are constantly taking steps to keep control of our own profession. It is not the business of insurance.

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involving the responsible people, those who have received these services and those who have given them, sitting down in a workshop fashion are come to an understanding. This is a voluntary process which in our way of life we feel is a satisfactory one and that you cannot legislate satisfactorily in a blanket

DR. SULLIVAN: If I can make a comment on that -- would I be permitted also?

THE CHAIRMAN: Yes.

DR. ALICE-LOCKHART: I think that we have to divide the question in two halves and really the question is, what the chairman was talking about, is control of abuses of the plan.

COMMISSIONER VAN [illegible] I did not [illegible] there.

DR. ALICE-LOCKHART: If you are talking about the control of the quality of the service of the physician, this is not the business of insurance. This is the business of the medical profession and we handle this in various ways and we are constantly open back of it. We are constantly trying ways to keep control of our own profession. It is not the business of insurance.

L/ss

COMMISSIONER VAN WART: The criticism is really justified then, is it, of the plans?

DR. BRUCE-LOCKHART: I do not think so. I do not think it is a justified criticism of the prepaid plans which are insuring bodies should exercise a disciplinary function or a quality control function over the services of they physicians. That they should exercise a control of abuses of the plan, yes, but that they should exercise a control which I think was really your question, over the quality of services, no, sir.

COMMISSIONER VAN WART: Are you aware of the United States where there are certain groups insured such as the H.I.P. group, for instance, which consists of numerous groups of doctors in under one plan?

DR. BRUCE-LOCKHART: Yes.

COMMISSIONER VAN WART: That plan makes rules and regulations concerning the quality of care given by the groups.

DR. SAWYER: Would it not be more fair to state that the H.I.P. chooses its groups with great care and they have to have certain qualifications before they may be employed by a group. Now, to go beyond that -- I think it is left to the professional self-discipline within the group. They choose their people with care.

THE CHAIRMAN: They have a medical review committee?

COMMISSIONER VAN WART: The plan has a medical review committee.

DR. SAWYER: Composed of doctors so it is professional self-discipline.

COMMISSIONER VAN WART: The plan is

COMMISSIONER VAN NEST. The question is really justified then, is it, of the phase?

DR. JACOB-LOCKHEED. I do not think so. I do not think it is a justified criticism of the proposed phase which are inserting. Odes should exercise a disciplinary function or a quality control function over the activities of they physicians. That they should describe a control or aspect of the plan, yes, but that they should exercise a control which I think was really your question, over the quality of services, no, sir.

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MR. DIAMANT. They have a position.

COMMISSIONER VAN NEST. The plan has qualified for its conditions.

DR. JACOB-LOCKHEED. Chosen it carefully so it is professional and fair.

COMMISSIONER VAN NEST. The plan is

different to your voluntary plans then, that you referred to your Ontario Medical Association groups, it is a different concept?

DR. BRUCE-LOCKHART: It is a different concept, the plans are insurance agencies, prepaid mechanisms.

COMMISSIONER VAN WART: Do you wish to express an opinion on this H.I.P. concept of the plans having medical disciplinary committees, so to speak?

DR. BRUCE-LOCKHART: There are many ways of doing many things; your closed panel clinic, of course, can do the same thing, it can appoint a medical director and he controls what goes on inside that clinic. These things are developing in various ways, they have some advantages, perhaps, but they have some disadvantages. I think the evolutionary process and the test of time will tell us the best way of doing various things. I do not believe that control of a profession is properly the problem of an insuring agency. This is a professional problem because you are concerned not with the people in the plan only, but with the standard of all the profession in the Province, and for that matter, in the Dominion.

DR. ATKINSON: I think it would be fair to say that frequently there is an involvement of financial aspects tied in with medical care and it is the opinion of this Association that medical care should not be influenced by the economic climate under which it operates, that the people should be assured of the best medical care and the other things should not interfere with this normal development, the voluntary process of providing good medical care which we believe is available now.

different to your voluntary plans than, that you referred to your Ontario Medical Association groups, it is a different concept?

DR. BRUCE-LOCKHART: It is a different concept, the plans are insurance operations, prepaid mechanisms.

COMMISSIONER VAN WART: Do you wish to express an opinion on this H.I.P. concept of the plans having medical discipline committees, so to speak?

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DR. HUCKNSON: I think it would be safe to say that frequently there is an involvement of financial agencies tied in with medical care and it is the concern of this Association that medical care should not be influenced by the economic climate under which it operates, that the people should be assured of the best medical care and the other things should not interfere in this general development, the voluntary process of providing good medical care which, we believe is usually the case.

COMMISSIONER VAN WART: Just one other question along another line; why does not the Municipality of Toronto participate in the hospital construction grants? Is there a reason for that?

DR. SAWYER: Well, I cannot speak for the Municipality of Metropolitan Toronto, but whether it is significant or not, the contributions stopped when the Government hospitalization plan came into effect. I will leave you to surmise.

COMMISSIONER VAN WART: Thank you.

THE CHAIRMAN: Thank you very much.

Gentlemen, as spokesmen for the Ontario Medical Association, as I said at the beginning, your brief contains factual material and information that is going to be of great value to us in consideration of the problems that we have to deal with as we go forward towards arriving at some conclusions.

DR. McCREARY: Mr. Chairman, on behalf of myself and my colleagues gathered here I would like to express their appreciation for the consideration and many courtesies extended to us at this hearing. We have indicated we will be pleased to furnish further information if desired at a later date. On behalf of the Ontario Medical Association, I would like to thank you.

THE CHAIRMAN: Thank you very much. We will recess now until 2:15.

---Luncheon Recess.

COMMISSIONER VAN WART: Just one other question along another line; why does not the Municipality of Toronto participate in the capital construction grants? Is there a reason for that?

DR. SAUER: Well, I cannot speak for the Municipality of Metropolitan Toronto, but whether it is significant or not, the contributions stopped when the Government hospitalization plan came into effect. I will leave you to surmise.

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THE CHAIRMAN: Thank you very much.

We will recess now until 2.15.

---Luncheon Recess.

--- On resuming at 2.15 p.m.

THE SECRETARY: Mr. Chairman, I would like to call forward the Canadian Association for Retarded Children. Mr. Hall will call on his group. This submission will be known as Exhibit 239.

--- EXHIBIT NO. 239: Submission of the Canadian Association for Retarded Children.

THE SECRETARY: I would like also to state that the Ontario Association for Retarded Children is here at the moment. Perhaps you would like to make a statement.

THE CHAIRMAN: Insofar as the Ontario Association is concerned, we thought it might be desirable if you did hear what the Canadian Association had to say and listen to any questions that may be put. It may provide for more continuity, and so forth, as the briefs are dealt with.

SUBMISSION OF THE CANADIAN ASSOCIATION FOR RETARDED CHILDREN.

Appearances: Mr. L.H. Hall
Dr. H.F. Frank
Dr. John C. Stanley

MR. HALL: This is Dr. Frank on my left and Dr. Stanley on my left. They are both consultants.

This is Part One of our brief headed "Summary and Recommendations".

Mental retardation is a major health problem affecting some 3% of our population. Increased public and professional interest over the past several

--- On resuming at 2.15 p.m.

Mr. Hall: I would like to call forward the Canadian Association for Retarded Children. Mr. Hall will call on his group. This submission will be known as Exhibit 249.

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MR. INGERMAN: Insofar as the Ontario Association is concerned, we thought it might be helpful if you did hear what the Canadian Association had to say and listen to any questions that may be put. It may provide for more continuity, and so forth, as the panels are dealing with.

<u>PRESENTATION BY THE CANADIAN ASSOCIATION FOR</u>

Mr. Hall

Mr. John A. Stone,

Mr. Hall: This is Mr. Stone on my left and Mr. Stanley on my left. They are both consultants. This is Miss Ida of our social service

Mental retardation is a major health problem affecting one in one hundred. Advances made in medical and educational services over the past decade

decades has been paralleled by increased investment in services. However, because of the high incidence, the wide range of services required and previous neglect of the problem, our present provisions are in all respects inadequate.

> "All children irrespective of whether or not they suffer from mental or physical handicap, should have every access to the best medical diagnosis and treatment, allied therapeutic services, nursing and social services, education, vocational preparation and employment. They should be able to satisfy fully the needs of their own personalities and become, as far as possible, independent and useful members of the community". (Ref: World Health Organization - Technical Series Report No. 75)

Experience would indicate that some degree of social and economic independence is presently a feasible goal for most of the retarded, and that for the others, much can be done towards their well being and reduction of the burden they place on their families and their community.

To ensure the most favourable adjustment to their handicap, the retarded require the following range of services:

1. Diagnostic and clinical services to find cases early; to secure treatment

of orthopedic, hearing, eye, or other accompanying defect; to undertake immediate and long term planning for the child and family; to provide continuing supervision, guidance, and the necessary clinical re-evaluation as the child moves through the various phases of its development and training.

2. A home visiting service to support and guide the family when necessary in the physical and emotional care of the child and in its training.

3. Community school facilities for all trainable and educable retarded children with specially trained teachers and curricula geared to the particular potentials of the retarded child.

4. Vocational training, sheltered work shops, and job placement services for the employable; occupational centres and day care centres for those requiring permanent supervision.

5. Specially directed recreation programmes.

6. Adequate institutional facilities with active programmes for retarded children who because of particular social circumstances, physical and emotional disabilities, cannot be maintained in community programmes.

of children's hearing, eye, or other

immediate and long term planning for the child and family; to provide counselling supervision, guidance, and the necessary clinical re-evaluation as the child moves through the various phases of his development and training.

2. A more visiting service to support and guide the family when necessary in the physical and emotional care of the child and in his training.

3. Community school facilities for all training and educable mentally children with specially trained teachers and clinic in addition to the extraordinary requirements of the retarded child.

shops, and job placement services for the supervisory occupational centres and day care centres for continuing training or rehabilitation.

5. Specially designed residential

6. Special Care Institution facilities and care programme for exceptional children who require of supervised social development, physical and medical treatment, emotionally disturbed

7. Foster home and hostel facilities for retarded persons who cannot be looked after in their own homes because of family circumstances.

Substantial reduction in the incidence of mental retardation and optimal care must be our ultimate goals. Valuable preventive work of a general nature is now being done by our services in the fields of antenatal care, obstetrics, health supervision in neonates and young children. Strengthening of these services to their fullest efficiency and their full extension to all Canadian mothers and children, would be valuable. There is now sufficient knowledge of certain disorders causing mental retardation (treatable diseases such as phenylketonuria, diseases inherited in a predictable pattern such as tuberous sclerosis) to enable the prevention of specific types of retardation through programmes of screening treatment and genetic counselling.

Research in a wide range of basic and applied fields is urgently needed to enhance our preventive capacities and to make more effective our methods of care and habilitation.

There remains widespread ignorance and misunderstanding of the retarded. Public education is a prerequisite to the development of a comprehensive programme for the retarded. In this field, the Canadian Association for Retarded Children has a particularly responsible role.

In considering the steps to be taken in the development of a comprehensive programme, it has been

7. Better care and more facilities for retarded persons who cannot be looked after in their own homes because of family circumstances.

Substantial reduction in the incidence of mental retardation and cerebral palsy must be our ultimate goals. Valuable preventive work of a general nature is now being done by our services to the child

maternity and young children. Strengthening of these services in their valuable research and their full extension to all Canadian citizens and children, would be valuable. There is very sufficient knowledge of certain disorders causing mental retardation (mental illness such as phenylketonuria, diseases inherited in a recessive pattern such as Tuberous sclerosis) to enable the prevention of a similar degree of retardation through pro-

Research in a wide range of basic and applied fields is urgently needed to enhance our preventive capabilities and to make more effective our methods of care and rehabilitation.

There is widespread ignorance and misconceptions in the community. Public education is a prerequisite to the development of more preventive programs for the retarded. In this field, the Canadian Association for Retarded Children has a particularly

[illegible]

In summarizing the steps to be taken in the development of a comprehensive programme, it has been

borne in mind that we are concerned with a very large relatively undeveloped field. In it there is an extreme shortage of competently trained professional people, a great research need and a lack of community understanding and initiative.

It is acknowledged at the outset that the provision of services for the retarded must involve both government and voluntary agencies at all levels of administration. Little attempt will be made in this Brief to indicate the relative responsibilities of these groups, except in the most general terms. The purpose has been to outline the magnitude of the problem of care for the retarded and the national effort which will be required to meet the need.

The magnitude of the needs and the financial requirements to meet these needs are such that it will take a number of years to develop the necessary programmes and services. The problem of dealing with the mentally retarded with I.Q.'s of 0 - 75 is of such magnitude that we have made no recommendations in respect of a large number of children falling into the zone between the mentally retarded and the slow-learners referred to as "Borderline Retarded".

Statistics on the problem of mental retardation are incomplete but the figures used in this Brief relating to the number of mentally retarded, the personnel required to supervise them, and expenditures for appropriate programmes have been estimated by experienced people from such statistics as are available.

homes in rural that we are concerned with a very large relatively undeveloped field. In it there is an extreme shortage of competently trained researchers people, a great research need and a lack of communication understanding [illegible]

It is acknowledged by the author that the promotion of activities for the retarded must involve both a recognition and voluntary agencies at all levels of administration. Hence attempt will be made in this paper to indicate the active responsibilities of these groups, except in the most general terms. The purpose has been to outline the magnitude of the problem of care for the mentally [illegible] the national effort which will be required to meet the need.

The [illegible] of the rural and the financial requirements to meet these needs are such that it will take a number of years to develop the necessary personnel and services. The problem of dealing with the mentally retarded adults is only [illegible] of such magnitude that we have made no recommendations in regard to some number of children [illegible] into the home between the mentally retarded and the slow-learners referred to as "borderline retarded".

Statistics on the mentally retarded.

Population are [illegible] but the figures used [illegible] based relating to the number of mentally retarded, the personnel required to staff the [illegible], and the [illegible] for supervised [illegible] have been estimated by [illegible] and [illegible] characteristics [illegible]

Recommendations

We would make the following recommendations:

1. That the federal government assist the provincial governments towards the eventual establishment of fifteen (15) Assessment Clinics related to medical training centres and children's hospitals.

2. That the federal government encourage and assist universities and institutions to provide training facilities for physicians, social workers, psychologists, genetecists, remedial teachers, physical fitness and recreational workers, and other specialized personnel necessary to staff the various services for retarded persons.

3. That the federal government increase its grants to Provincial Departments of Health to strengthen and extend community mental health services and general health supervision services to the retarded. Inherent in this recommendation is the need to extend in service training and staff development programmes for existing professional staff.

4. That the federal government, as well as private foundations, and volunteer organizations substantially increase their support for research in areas

related to mental retardation. It is necessary to note that research into problems of teaching, of vocational preparation, of mental, emotional and social development, as well as research into the medical aspects of retardation is needed.

5. That the federal government increase its assistance to the provincial governments to establish and maintain institutional programmes.

5a. That the federal government make available to the provinces matching grants to cover capital and operating costs of vocational training and placement services for the retarded.

6. Through voluntary community effort, considerable funds are being raised and invested by voluntary groups in a variety of services for the retarded. The Canadian Association for Retarded Children has a responsibility in stimulating and guiding community effort, and in the field of public education. We would recommend that the federal government increase its annual grant to $50,000.00 to support this Association in these functions.

7. As a basis for long term service and research planning, it is recommended

[illegible] is equal to education. It is necessary to look that research into problems of training, of vocational rehabilitation, of health, educational and social development, as well as research into the national aspects of [illegible] research.

[illegible] its assistance to the provincial governments to establish and maintain industrial programmes.

[illegible] that the federal government [illegible] available to the provinces matching grants to cover capital costs of training centres or vocational training [illegible] and services for the unemployed.

6. Through voluntary contributions of cash, [illegible] consumable funds are being raised and [illegible] by voluntary [illegible] in a variety of services for the returned. The Canadian Association for Retarded Children has a [illegible] ability in stimulating and [illegible] community effort, and in the [illegible] of [illegible] organization. [illegible] [illegible] that the federal government [illegible] [illegible] part to [illegible] to support this Association [illegible] [illegible].

7. As [illegible] for [illegible] [illegible] research planning, it is recommended

that voluntary agencies co-operate with governments in the establishment of registries for the handicapped and that liaison be established between voluntary and official agencies to ensure that standard procedures are adopted to provide uniformity of information.

8. That the federal government amend the Disabled Persons Act by reducing the present age of 18 to 16 years.

9. That voluntary agencies, local and provincial authorities be educated as to the recreational needs of the retarded, encouraged to support existing programmes, and to assist in developing new ones. The agencies should use the resources provided under the new Physical Fitness Act.

Many government departments as well as private agencies and organizations are involved in the development of services for the retarded. It would seem essential that all participating groups should understand the comprehensive needs of the retarded and the relation of their particular contribution to the total plan. Therefore the final recommendation is that each provincial government establish co-ordinating committees representing the various government departments and private organizations concerned with the development of services for the retarded. To be effective, each committee should have staff service and an operating budget. These provincial

[illegible]

[illegible] with responsibility in the area [illegible] responsibility for the [illegible] and a joint liaison is established between military and civilian agencies to insure that [illegible] are adopted to insure [illegible] of [illegible].

6. That the Federal government repeal the Draft or Service Act [illegible] the present age of 18 to 19 years.

7. That voluntary agencies, local and municipal authorities be encouraged as to the rehabilitation needs of the [illegible], encouraged to support existing programs and to assist in developing new programs [illegible] agencies should see the [illegible] provided under the new Revised Uniform [illegible].

[illegible] government authorities as well as private agencies and organizations are involved in the rehabilitation of the [illegible]. It would seem essential that all participating groups should [illegible] the [illegible] of the [illegible] and the [illegible] of their [illegible] to the total [illegible]. Therefore the [illegible] recommendation is that each private [illegible] organization establish [illegible] committees [illegible] with [illegible] government departments and private organizations [illegible] the development of services for the [illegible]. It is effective, [illegible] [illegible] and an [illegible] budget. [illegible]

committees should have representation on a similar co-ordinating group at the national level.

The balance of the brief contains the case figures and population affected. Thank you.

THE CHAIRMAN: Thank you very much, Mr. Hall.

Have you, Dr. Frank or Dr. Stanley, got anything to add at the moment?

DR. FRANK: No, sir, not unless there are any questions which the Commission may have.

DR. STANLEY: Not at the moment, Mr. Chairman.

THE CHAIRMAN: You make a recommendation on page 5, No. 8. The answer may be in the brief, but it has escaped me at the moment. You recommend that the Federal Government amend the Disabled Persons' Act by reducing the present age of 18 years to 16 years. What is the significance of that recommendation?

MR. HALL: I think the prime significance, sir, is that 16 is the school age, and we feel that the reduction should be made to 16 so that when the school is over the parents would then be assisted financially in cases where the children have to stay at home, under the scope of the Disabled Persons' Act.

THE CHAIRMAN: The right to assistance arises at 18 now?

MR. HALL: Yes.

THE CHAIRMAN: There might be that two-year level.

[illegible]

The minutes of the [illegible] concerning the case figures and consultation sites is [illegible]. Thank you.

The [illegible]. Thank you very much.

[illegible] right.

Have you, Dr. [illegible], or [illegible], not anything to add at the moment?

Dr. [illegible]: No, Sir, not at this time. [illegible] are any questions which the Commission may [illegible].

Dr. [illegible]: Not at the moment, Sir.

[illegible] Commission.

Mr. [illegible]: You made a recommendation on page [illegible] of the report [illegible] it was because, at the moment, you [illegible] [illegible] Government [illegible] the Disable[illegible] [illegible] [illegible] by the [illegible] age of 18 years to 16 years. What is the significance of that recommendation?

Dr. [illegible]: I think the prime significance, is that it at the school age, and we feel that the teachers should be able to [illegible] so that when the school [illegible] over the property [illegible] then be assisted [illegible] in cases where the children have to stay at home, under the terms of the Crippled Persons' Act.

Dr. [illegible]: The right to [illegible] [illegible] at 16 now?

Mr. [illegible]: Yes.

Dr. [illegible]: There might be that [illegible] [illegible].

BB/ss

Are you able to say how many provinces in Canada have recognized, where the educational departments, educational systems in the provinces have recognized its responsibility for the education of the retarded child?

MR. HALL: I think most provinces have recognized it in varying degrees. In most cases I think the situation is that some children are given education in the public school system and some children are given education in the schools operated by member associations of this Association for which grants covering only part of the cost are made by the Provincial Governments concerned. In some of the institutions there is some education carried out. This once again comes under the Provincial Department of Health. However, in other instances we don't feel that the retarded children are being, all retarded children are being given the fullest opportunity to be trained to their fullest potential.

THE CHIARMAN: Where the child is being educated in the elementary school system does that apply only to the children in the area or is there a provision for foster homes, for the bringing of children from rural sections?

DR. FRANK: In this, first of all, the public school systems will provide education only for a number of their retarded children in keeping with their level of disability. In most provinces I think the common figure is related to intelligence quotient of fifty. In very few of the rural areas, however, are there facilities for the education of the retarded child. This by reason

of the sparcity of the numbers and the distance concerned, so that in a sense there is departmental discrimination against being born and brought up in a rural community if you are a retarded person. Not being easily available these facilities are cut off for the retarded group. The possibility of providing foster homes for certain retarded rural children so that education can be carried out is a matter, first of all, of finding foster homes, and secondly of getting the consent of parents to have the children withdrawn from them. These two extremes, in a sense, present certain problems and certain difficulties.

THE CHAIRMAN: Is there any organized effort to that effect?

DR. FRANK: There isn't any great organized effort to that effect, as far as I know, except in relation to the Children's Aid Societies. These are in relation to children who have no homes of their own.

THE CHAIRMAN: What about the medical care, the physicians' services for retarded children, how adequate or inadequate are they?

DR. STANLEY: I think we would feel that generally they are very inadequate at the moment, perhaps, not quite so much at the diagnostic level. Most Canadian children at the moment do have access, I believe, to relatively good diagnostic examination facilities. I think the lack is rather more in the area of continuing following up of these children and in relation to the guidance of the parents and the planning for the children, and the re-evaluation we mentioned as the child grows older. The cooperation that should exist, presumably,

between the medical services and the habilitation services--it is in this area we lack, both in the medical and habilitation field. I might mention as far as general medical care for these children, medical care, dental care the standards tend to be lower for a number of reasons. These children are more difficult to look after. It is more difficult for parents to get them into the doctor's office. In the doctor's office they require more time and attention. They are harder to examine, harder to deal with. It is perhaps more readily appreciated in dental work which ordinarly could be done without anaesthesia, that these children must require anaesthetic facilities. It would be my feeling that the standard of medical care for the retarded tends to be rather lower than for the ordinary child. Of course, this is particularly regrettable because so many of these children do have medical defects. Deafness, the incidence of deafness, partial deafness is probably three or four times as great as in the normal child, also orthopaedic problems, eye problems. Their need for medical care would seem to be greater, and yet I would feel the standards of medical care we offer at the moment are rather less.

THE CHAIRMAN: You have your medical care prepayment plans in the various provinces. Do these plans provide the psychiatric care that the retarded child appears to require? Are there insured services?

DR. STANLEY: No, sir.

THE CHAIRMAN: Probably why, the answer is in many instances because, I take it, the province has been accepting the load of all those who

become institutionalized.

DR. STANLEY: Quite. The amount of service at the moment is being extended through mental health clinics and existing services, but by and large the attention to those aspects again, habilitation aspects, has tended not to receive the amount of attention it deserves. Our mental health clinics, by and large, are over-worked. I think 30 to 40% of the case load consists of retarded children, but the energies of the people are generally directed to the care of the emotionally disturbed children who, perhaps, have a better chance for retraining, who accept better psychiatric treatment and at this time I think this group has tended to suffer.

THE CHAIRMAN: Now, as to the size of the group, you mentioned this figure of 3%. That is on a country-wide basis.

MR. HALL: Yes.

THE CHAIRMAN: Can you reduce that to figures in terms of say, under sixteen, what it would be?

MR. HALL: We could do that for you, sir. It is on page 46 of our brief. Would you like me to read the figures?

Children of 0 to 4 years of age -- is it all right if I read it in round figures and leave off the odd ones?

THE CHAIRMAN: Yes.

MR. HALL: 59,000; 5 years to 19 years 132,000; 20 years to 24 years, 34,000; 25 years to 34 years of age, 72,000; 35 years to 44 years, 64,000; 45 years to

54 years, 48,000; 55 years to 64 years, 34,000; 65 years to 69 years, 14,000 and 70 years and over, 23,000.

THE CHAIRMAN: You start with group 5 to 19, you haven't made a break at the 16 year period you mentioned.

MR. HALL: No, sir. I could do it for you if I had a few minutes.

THE CHAIRMAN: I suppose this 5 to 19 would be a pretty relatively consistent figure in that 132,000?

MR. HALL: I think roughly we would divide them by 15, which would be about 9,000 for each year. If you were concerned with this 5 to 16, there would be about 105,000.

THE CHAIRMAN: Now, the matter of education of the retarded. I take it you are not satisfied with the present method. There should be something better?

DR. FRANK: It is a matter of insufficiency of facilities to provide adequate overall diagnosis of the children's disabilities. I think that one thing we should not forget in relation to the retarded is we are dealing with the possiblity of multiplicity of handicaps and not just a deficiency of learning. For this reason the extreme importance of overall and complete and full diagnosis of the child with its totality of disabilities is important in relation to the disability of learning. So that, for example, it becomes very important to know the retarded child is deficient in hearing or deficient in vision or a possible emotional problem which complicates

the basic retardation from which the child suffers. It is for this reason that we feel there is a very definite insufficiency of facilities to provide the very important overall diagnosing process for these children.

MR. HALL: I might say, sir, that the advances in Europe, particularly in England are much further ahead than we are here. I think it is understandable, perhaps, because we have a younger country. Services that are in Canada at the present time are grossly inadequate to meet the needs in practically every area.

COMMISSIONER McCUTCHEON: What are the services in England, generally, that are available, that are not available here?

MR. HALL: There is a scrolling in the first place for all retarded in England. They have a system whereby people that are handicapped are registered at birth, and then there is a follow-up made of the children.

THE CHAIRMAN: Those are physical disabilities?

MR. HALL: As well as mental handicaps where it is obvious. Those are continuing registrations where the parents bring their children or the doctor is reporting their children, so that their handicaps can be officially recorded. This is done in order to enable the authorities to give the proper treatment and training for these children with a consequence that you will find children in Britain who are welding parts to make television sets, which, I think, is to us here in this room probably something that is fantastic when we

relate our conception or some of our conceptions of what the retarded child is like. They are trained in England to be fruitful and to be employable where it is possible.

THE CHAIRMAN: Over what period of years has this system been developed?

DR. FRANK: In England?

THE CHAIRMAN: In England.

DR. FRANK: I would say possibly at a good rate since the last War. As a matter of fact, a good many of the present facilities are provided for the retarded in relation to medical care programs, have been in relation to the development of their National Health Scheme. I don't think there is much doubt about that.

THE CHAIRMAN: That is the next logical question.

DR. FRANK: I thought you were getting to it.

THE CHAIRMAN: What has been the effect?

DR. FRANK: That is basic.

THE CHAIRMAN: What has been the result of the National Health Scheme that has caused them to have a better program?

Hall

relate our conception or some of our conceptions of what the ideal world is like. They are trained in regard to be fruitful and to be equipped where it is possible.

THE CHAIRMAN: Over what period of time has this system been developed?

DR. FRANK: I would say possibly at a good date since the last war. As a matter of fact, a good many of the present facilities are provided for the regarded in relation to medical care programs, have been in relation to the development of their National Health Scheme. I don't think there is much doubt about that.

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THE CHAIRMAN: What has been the effect

DR. FRANK: That is basic.

THE CHAIRMAN: What has been the result of the National Health Scheme that has caused them to have a parte programs?

It would seem that a rapid survey of the picture, and I make this as a qualifying point, because more and more adequate diagnostic services, care services for the retarded are being provided in England than in our own country.

THE CHAIRMAN: If you are in a position to give an opinion on this next proposition, well and good. If not, just say so. In terms of Canada what do you see the situation to be in terms of physician care to the retarded as compared with the non-retarded and for the future should some priority be set up in favour of one as regards to the other?

DR. FRANK: I think it is difficult to talk about priority,because any person who has a personal interest as this has a priority interest so that it is rather difficult to be very objective about a thing of this kind.

THE CHAIRMAN: I mean is there anyone who is not interested in the retarded child?

DR. FRANK: Well, we feel that this is quite so. That there is not a sufficient -- I think we tried to make a point of this in our brief -- that one of the recommendations on a national program for the retarded is the public education of professional people as well as the public generally as to the, first of all, the immensity of the problem. Secondly, what can be done about it with an adequate approach, so that a great deal of salvaging can be done out of our presently derelict population.

MR. HALL: I think an important thing

It would seem that a radio survey of the picture, and I was just as a qualifying point, requires more and more adequate diagnostic services, and services for the related arts being provided in England than in our own country.

Mr. CHATHAM: If you are in a position to give an answer on this last proposition, well and good. If not, just say so. In terms of a year from now do you see the situation to be in terms of lines more to the point as compared with the pre-stamped and in the future should some provision be made in favor of one as regards to the other?

Mr. FRANK: I think it is difficult to talk about relative, because my reason, personal interest as this has a priority interest so that it is rather difficult to be very objective about a thing of this kind.

Mr. CHATHAM: I mean is there anyone who is not interested in the internal child?

Mr. FRANK: Well, I am sure that this is quite so. The case is not a sufficient -- I think we tended to make a point of this in our brief - that one of the recommendations in a national program for the remedial in the public education of prospective parents as well as the public generally as to the, first of all, the immaturity of the publics. Secondly, what can be done about it with an adequate approach, so that a great deal of damaging can be done out of our pre-early days of

Mr. CHATHAM: I think an important thing

here is that the physician certainly has a part to play in this. If we interpret the position in the very broad sense, in order to do anything about this problem, we have to have better clinics. Now, here the need is to find more physicians, once again in general terms, to enable us to get these additional clinics, and all through the program of the retarded towards this habilitation you will find, if we can use the term professional people instead, we need a great number of professional people.

We need psychiatrists. We need psychologists. We need social workers and many types of therapists in this type of thing. So that to get back to your question of the physicians, we certainly, in our brief, present you with this need to obtain more physicians interested in our work, and also to undertake, or to get physicians to have a much greater knowledge of the problems of retardation.

THE CHAIRMAN: What inter-relationship, if any, exists or may exist between the retarded child and the mentally ill child?

DR. FRANK: Well, there is no definite relationship if by this you mean does a mentally defective child become mentally ill. There are two categories. There are mentally ill children who present problems of retardation because of their mental disorder, or mental illness rather, and there are mentally retarded children who may or may not become mentally ill.

However, there is a greater tendency on the part of mentally retarded children to present the emotional problems, or some aspect of a neurotic behaviour

part is that the physician certainly has a part to play in this. If we understood its position in the very broad sense, in order to do anything about this problem, we would to have better [illegible]. Now, [illegible] need [illegible] more physicians, once again in general terms, to enable us to get [illegible] [illegible] the research of [illegible] towards this [illegible] find, if we can use the [illegible] [illegible] [illegible]

[illegible] psychiatrists, as well as psychologists. We need social workers and many other [illegible] therapists in [illegible]. But [illegible] get back to your question of the physicians, we certainly, in our belief, [illegible] you with this need to obtain more physicians interested in our work, and also to undertake [illegible] to get [illegible] to have a much greater [illegible] of the problems of retardation.

[illegible], exists or any relation between the mother and child and the heredity of the child?

Dr. [illegible]: Well, there is no definite relationship [illegible] definitely detected [illegible]. There are two categories [illegible] present problems [illegible] [illegible], are there are medical [illegible] [illegible]

[illegible]

[illegible] children, to present the [illegible]

to an extent much more commonly than occurs in a normal, intellectually normal child.

These people, because of their retardation, and the implications which surround this sort of thing, particularly social implications, do become more emotionallly disturbed more frequently than does the normal child.

THE CHAIRMAN: What liaison exists between your Association and the Association for the Mentally Ill?

DR. FRANK: There is no structural liaison. There is mutual knowledge of the existence of such two groups.

Occasionally they may meet together to discuss problems of mutual interest because both of these groups, what they are presenting is a child with a difficulty in learning and this is the problem which the group related to the emotionally ill child is trying to solve as well as this group whose basic interest is the mentally retarded child.

Beyond this professional interest there is no structural connection between the two, as far as I know.

MR. HALL: There is a liaison between the two organizations, but since there is no similarity in condition, the liaison is the most desirable arrangement.

COMMISSIONER McCUTCHEON: I am looking at your table, Page 46 and I see that 83% of the mentally retarded, which is a big percentage, leaves the balance

to an extent such are commonly then occurs in a [illegible]
line textually normal world.

These people, because of their rather
[illegible], are the least [illegible] to record this sort of
[illegible], particularly [illegible], to become more
emotionally distorted [illegible] than does the

[illegible]

[illegible] between [illegible] associations and the [illegible] to the

[illegible]

[illegible] reason. There is without knowledge of the existence of
such two [illegible].

[illegible] to [illegible] of [illegible] [illegible] [illegible]
these [illegible], [illegible] they are [illegible], [illegible] with a
difficulty in [illegible] a rule is the problem which the
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] to
[illegible] as [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible].

[illegible] this [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
as I know.

[illegible] There is a [illegible] [illegible]
the two [illegible] [illegible], [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
[illegible].

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
[illegible], [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

down below 1% -- well below 1% of the population have an intelligence quotient of between 50 and 75 and I forget the term you used in describing those, but is it educable?

DR. FRANK: Yes.

COMMISSIONER McCUTCHEON: Once they are identified and once they pass a certain number of years isn't the problem from there on a purely educational problem as distinct from a health problem for that large group?

DR. FRANK: Yes, I would agree that the greater percentage problem is one of habilitation rather than the provision of very narrow medical care, although we do include in the total approach to this group, as to any group, the fact that an adjustment to adequate living is part and parcel of a medical approach, or a health approach to this person.

MR. HALL: I would also like to point out in this connection that fully 15% of this group, usually at varying times, are going to need the type of service which we have been talking about for other groups. That is, they do suffer from emotional problems and in the future, that is after they leave school, there will be also, in some cases, the need for vocational training -- perhaps of an extended type, or vocational situations where they can function better than they are able to at the present time because the educational system in many parts of Canada does not go far enough.

Whether it's an educational problem or a Department of Labour problem perhaps needs to be identified a little bit finer. That is, after they have

ions below 18 -- tell me, in your opinion, is an intelligence quotient of seventy-five? I don't know the term you used in those long cases, but it sounds, Mr. Chairman, so.

are identical and give them the - certain number of years. Isn't the problem how there or a mentally e-ceptional problem as distinct from a health problem that lies

Mr. MARTIN: Yes, I think that the greater penitentiary problem is one of institution.

Although we do include in the total admissions to a group, as to any group, the idea that an offender is deserving living in a penitentiary instead of a reformatory, or a health institution, is this person

Mr. [illegible] I would also like to point out in this connection that fully half of this group, mentally at very low times, are going to need the type of service which we have been talking about for other people. That is, some of our mentally exceptional problems are in the future, that is after they have served, there will be also, in some cases, the need for continuing training -- perhaps of an extended nature, or vocational counselling so that they can function better than they are able to do at the present time. I mean the educational system in many parts of Canada does not do this.

Perhaps, Mr. Chairman, the question of a forerunner or [illegible] psychiatrist has to be constituted a [illegible] [illegible], [illegible] [illegible]

left school.

COMMISSIONER GIRARD: Page 1 summary and recommendations, under No. 2, you spoke of -- in connection with diagnostic and clinical services and home visiting services to support and guide the family. What category of personnel would you have in this home visiting service?

MR. HALL: Public nursing, Public Health nursing type of personnel or some type of nursing personnel, particularly, as the prime relationship between the home and the health service.

COMMISSIONER GIRARD: Do you have any of these home visiting services now?

DR. FRANK: There are, to some extent.

MR. HALL: Spasmodically within our own groups, and some agencies have them.

DR. STANLEY: I might perhaps add that there have been steps taken in this direction by the Department of Health in New Brunswick. They have establishmen for a close liaison between the mental health clinics and public health nursing service and it will assist the nursing service in establishing a home visiting service.

I would agree that certainly for the younger child that the public health nurse, who generally has quite a good awareness of the community and has also an entrance into homes where young children are, is the ideal person for guiding the family with the young child. Although possibly in the case of in the emotionally disturbed child where you have parents with family problems, that the social worker is a useful person to handle the

emotionally disturbed family but for the routine physical and general supervision of the young child, the nurse would seem to be the ideal visitor.

COMMISSIONER GIRARD: In your recommendations on Page 5, under No. 7, you also advocate the establishment of registries for the handicapped. This is the second or third time this has come up in one of the retarded children's briefs so I gather that it is pretty important for you to have the voluntary agencies and the official agencies get together on this. What is the outcome of not having these registries synchronized?

DR. FRANK: First of all, I don't think there are registries, as such. I don't anywhere in Canada, possibly except in the City of Vancouver, there is a complete registry of the handicapped persons in the local area.

There are many things of importance in relation to knowing your handicapped group, from the point of view of counselling if there are genetic relationships in the handicapped; from the point of view of anyone who wishes to do research surveys, research studies and so forth, to become involved either in one or more handicaps. We think it is quite important to have an on-going and continuing registry of all handicapped persons.

COMMISSIONER GIRARD: Would it be a means of reaching handicapped children that you cannot reach otherwise?

DR. FRANK: That is right.

COMMISSIONER GIRARD: This would be the primary connection, I would say?

[illegible] 5

emotionally [illegible] to the [illegible] value and general [illegible] of [illegible], the [illegible] would seem to be the [illegible].

CONTRIBUTOR [illegible]: In your [illegible] mentions or [illegible], you also advocate the establishment of a [illegible] for the [illegible]. This is the second [illegible] that has come in as a result of the [illegible] children's books so I believe that it is [illegible] important for you to have the volunteer agencies and the official agencies get together to [illegible]. What is the outcome of not having these negotiations [illegible]?

MR. [illegible]: First of all, I don't think there are negotiations, as such. I don't anywhere in Canada, possibly except in the City of Vancouver, there is a complete registry of the handicapped [illegible] in the local area.

There are many [illegible] of [illegible] in relation to knowing your handicapped [illegible] from the point of view of [illegible] if there are [illegible] in [illegible] in the handicapped from the point of view of anyone who [illegible] to [illegible] research surveys, research studies and so [illegible], [illegible] become involved either in one or more handicaps. [illegible] is quite important to have an [illegible] of all the handicapped persons.

CHAIRMAN: [illegible]: Would it be a [illegible] of [illegible] if you [illegible] [illegible]

[illegible]

[illegible]

[illegible]

DR. FRANK: That is right.

MR. HALL: I think it would help too, to plan the program for the future if you knew how many you have, and it would be an encouragement I think, to parents to have their children registered if they knew there was going to be a program for them.

COMMISSIONER FIRESTONE: You have submitted to this Commission a fairly comprehensive program involving large capital expenditures, and operating expenditures. I find that on page 73 you estimate capital expenditures of the program, if fully implemented, would reach a figure of $1,650,000,000.00, and then on page 74, in Exhibit 8, you provide us with an estimate of maintenance costs, which I take it are operating costs on an annual basis, of $267,800,000.00.

I was trying to compare these estimates of requirements with what is actually being spent in Canada now and I looked at your page 59 where you offer some estimates of operating expenses. There are two figures quoted on this page, 143,000,000 and then a figure of 85,000,000, after certain deductions. What I would like to know is which of these two figures ---- 143,000,000 or 85,000,000 is comparable with the $267,800,000.00 on page 74?

MR. HALL: You will notice looking at page 59 again and 74, that the net total of 85,000,000 is carried forward onto page 74. This $85,000,000.00, page 74, is a summary of all these exhibits. We have endeavoured to provide credit on page 59 for existing services, although I would like to point out in that connection that there are some 19,000 mentally retarded children in mental

[illegible]: That is right.

Mr. [illegible]: I [illegible] it would [illegible] too, to plan the program for the [illegible] if you knew how many you have, and it would be an encouragement, I think, to [illegible] to have [illegible] [illegible] if they [illegible] were going to [illegible] a program for [illegible].

[illegible]

[illegible] program involving large capital expenditures, and operating expenditures. I find that on page [illegible] you indicate capital expenditures of the program, if [illegible], would reach a figure of [illegible], and then on page [illegible], in Exhibit [illegible], you provide us with an estimate of maintenance costs, which I take it are operating costs on an annual basis, of [illegible].

I was trying to interpret these cost [illegible] of requirements with what is actually being spent in Canada now and I looked at your page 59 where you offer some estimates of operating expenses. There are two figures quoted on that page, [illegible] and then a figure of [illegible], [illegible] definition. What I would like to know is [illegible] of these two figures — [illegible] or [illegible] [illegible] with the [illegible] on page [illegible]?

Mr. [illegible]: You will notice looking at page 59 again and [illegible], that the total of [illegible] is [illegible] [illegible]. [illegible] [illegible], [illegible] of all these estimates, [illegible] to [illegible] on page [illegible] [illegible] existing services, although I [illegible] I [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

hospitals, and this is not a desirable place to have retarded children, but nevertheless, we have given full credit for the expenditures that are now being incurred.

COMMISSIONER FIRESTONE: Yes, I appreciate that. What I am tring to establish is the amount of increase in the program you are proposing to us. Do I understand from your answer that the current expenditure figure of all types, whether they are desirable or not so desirable, is something of the order of 85,000,000 and that a total program as and when complete would require $267,800,000.00. Are these two figures comparable?

MR. HALL: No. If we were able to get this program started tomorrow morning, I would be spending $267,000,000.00. The 85,000,000 is only one segment of the total.

Respects, are that is not a desirable place to have retarded children, but rather the, in view given full credit for the error there, that are now being improved.

Suggestion that W[illegible] train [illegible] the amount of increase in the program you are proposing to us. Do I understand from your [illegible] the current expenditure figure of [illegible], [illegible] are [illegible] or not? Realizing, in answering, the error of $4,000,000, [illegible] total program as [illegible] would require $[illegible],000,000.00. Are these the figures [illegible]?

[illegible] No. If we were [illegible] this program [illegible] tomorrow morning, I would be spending $[illegible]. The $8,000,000 is only one segment of the total.

COMMISIONER FIRESTONE: What does Canada spend now on looking after retarded children?

MR. HALL: Well, this can only be obtained by -- first of all, we are spending $58 million on institutions, in education. Mind you, we have to assume that these are retarded children with I.Q's of 75 or less. We are spending $6 million on education.

COMMISSIONER FIRESTONE: I beg your pardon?

MR. HALL: We are spending $58 million for institutional care; we are spending $6 million for education. On clinics, there is some expenditure but I am not sure what it is. I can assure you, however, that the amounts that we show on page 73 under capital of $15,500,000. and the amounts we show on maintenance of $13,800,000. are additional services which are needed. I think I would also like to say that there are disability allowances being paid which amount to some $8 million.

COMMISSIONER FIRESTONE: Well, if we look at your proposal in your perspective you suggest that there would be about $58 million spent on institutional care, $6 million on education, $8 million for disability allowances. Then, there must be some allowance made for another program for which you did not have a specific figure. If we add these three figures which you gave us it provides us with about $72 million and, let us say it could involve another $8 million so the present expenditures might be of the order of $80 million plus or minus. Am I right in that approximately you have

MR. HALL: Well, this can only be obtained by -- first of all we are spending 558 million on institutions, in education. Mind you, we have to assume that these are retarded children with I.Q.'s of 70 or less. We [illegible] spending [illegible] million on education

MR. HALL: We are spending [illegible] million on institutions. And, we are spending [illegible] million on education. On [illegible], there is some expenditure but I do not know what it is. I can assure you, however, that the amounts that we show on page 3 under capital of $25,000,000 and the amounts we show on maintenance of $15,000,000 are additional services which are needed. I think I would also like to say that there are quantity of services being paid which amount to some [illegible] million.

CONGRESSMAN FRELINGHUYSEN: Well, if we look at your statement, in your release [illegible] you suggest that there would be about 158 million spent on institutional care [illegible] on education [illegible] 8 million for disability allowances. Then, there must be some allowance made for another program for which you did not have a specific figure [illegible] these three figures which you gave [illegible] let us say [illegible] an additional [illegible] million to present expenditures [illegible] plus or minus [illegible] that approximately [illegible]

given us?

MR. HALL: You could be, yes.

COMMISSIONER FIRESTONE: That means, the suggestion of your program means you would like to see Canada carrying on a program which would be more than triple its expenditure; is that what you have in mind?

MR. HALL: That is exactly what we have in mind. I think it should be recognized from the number of children that we have shown here that we are not handling the problem, we are only scratching the surface of the problem and I think this is the difficulty. Naturally, we do not expect this problem or this money to be spent, it will take a long time for this money to be spent. People have to be trained and we have included in here amounts for training people. This amount is needed for two things, one, to take care of the present mentally retarded and, two, to develop the optimum program, which will do the most good. If, and I want to emphasize this, if we could give the retarded the type of training they need, spend this money to train them we are going to have a substantial number of children who will be in the community, they will not be in institutions, they will not be costing us $3,000.00 a year per head; they may be earning $3,000.00 a year, perhaps. This is the reason why we have indicated specifically all the different types of service and that is why the cost is so high. We have not done anything about this problem for years in Canada or, at least, we have only scratched the surface. We have not done enough.

Seven [illegible]

MOVE: Adopt the report. Just [illegible] the suggestion of [illegible] I [illegible] see Canada [illegible] on a [illegible] [illegible] than triple its [illegible] [illegible] have [illegible] more.

MR. [illegible]: [illegible] to [illegible] what we have [illegible]. I [illegible] it would be [illegible] [illegible] number of children that we have. [illegible] that we are not handling the problem, we are only [illegible] the advice of the problem and I think it is [illegible] [illegible]. Naturally, we do not expect this problem or [illegible] money to be spent, it will take a long time [illegible] money to be spent. People [illegible] to be trained and [illegible] involved in [illegible] the training [illegible]. [illegible] amount is [illegible] two things, one, to take care of the present mentally [illegible] and, two, to develop the [illegible] programme, which [illegible] to the [illegible]. It, and I want to emphasize this, if we could give the room to the type of [illegible] they need, [illegible] this money to train them we [illegible] to have a substantial number of children who will be in the community, they will not be in institutions. [illegible] not be costing us [illegible] a year per head. They may be costing $3,000.00 a year, perhaps. This is the reason why we have [illegible] [illegible] [illegible] types of [illegible] and that is why the cost is so high. We have not done anything about this problem for years it should be, it seems, we have only [illegible] the [illegible] as [illegible] not [illegible] [illegible]

COMMISSIONER FIRESTONE: I understand from what you said earlier you would visualize such a program to be implemented over a number of years. What number of years do you have in mind, a ten-year program? Would it be shorter or longer?

MR. HALL: As soon as we can get enough people encouraged to train in the different areas where training is needed and as soon as there is some leadership given to those people to encourage them to become active in these areas.

COMMISSIONER FIRESTONE: Is it only and encouragement or also money?

MR. HALL: Money is usually the best term of encouragement.

COMMISSIONER FIRESTONE: I am trying to visualize the difficulties a nation faces to increase expenditures on an annual basis from $80 million to $267,800,000. I am wondering what kind of period you would visual in implementing such a program? Would it be five years, ten years, longer or shorter?

MR. HALL: It would probably be ten years. I would like to assure you that we are trying to put up a reasonable proposition here but it is very difficult for us to say, for instance, how long it would really take because some of it depends on provincial responsibility. Of course, in some provinces the work is further advanced than in others. If the Provincial Governments were so inclined to really face the problem which they have in conjunction with financial help from the Federal Government this whole

program could be implemented in, perhaps, less than ten years.

COMMISSIONER FIRESTONE: If I understand you correctly, your proposal is to implement such a program as soon as the personnel, money and other arrangements can be worked out; if it takes ten years it is better to do it in ten years than not at all and if it can be done sooner it would be better. Is that what you have pointed out?

MR. HALL: Exactly.

COMMISSIONER FIRESTONE: Where would this money come from? This $267,800,000, are you visualizing the Federal Government contributing a certain proportion of it to the provinces -- you have been speaking on some occasions and using the phrase "matching grants"?

MR. HALL: Generally we would expect the Federal Government to make the present contributions of matching grants in areas where arrangements have been made with provinces. These areas, to my knowledge, are in personnel in training and capital costs and in some other parts. I think we would hope that the Federal Government might take a more generous attitude towards this financial assistance in that it would certainly speed up the process of getting our program implemented if the Federal Government would contribute a greater amount.

COMMISSIONER FIRESTONE: Is that your suggestion that the Federal Government should raise the percentage of programs to which it already contributes from 50% to a higher percentage or is your suggestion

program could be implemented in, perhaps, less than ten years.

[illegible] you correctly, your proposal is to implement such a program as soon as the personnel, money and other arrangements can be worked out; if it takes ten years it is better to do it in ten years than not at all and if it can be done sooner it would be better. Is that what you have pointed out?

MR. RAND: [illegible]

[illegible] There would be a money item [illegible] of $271,800,000, are you visualizing the federal government contributing a certain proportion of it to the provinces -- you have been speaking on other occasions and using the phrase "matching grants."

MR. RAND: [illegible] generally we would expect the federal government to make the present contributions of matching grants in areas where arrangements have been made with provinces. These areas, to my knowledge, are in personnel training and capital costs and, in [illegible] we would hope that the federal government might take a more generous attitude towards [illegible] assistance in that it would be taking towards the process of getting our program [illegible] the federal government would contribute [illegible]

[illegible] submit that the federal government should raise the percentage [illegible] grants in which it already contributes [illegible] higher percentage -- is your suggestion

that the Federal Government should commence contributing to programs in that field you are interested in where at the moment it makes no contribution or is it your suggestion that the Federal Government should do both?

MR. HALL: I think they should do both.

COMMISSIONER FIRESTONE: And if it were to increase its contribution from 50% to a higher proportion, what proportion would you suggest?

MR. HALL: I cannot say I have studied this particular problem, to be honest with you, but I think as we see it there has to be some reason why, apart from lack of interest in it and I do not think that exists at the provincial level with the programs having been developed. I think it is common knowledge in many provincial governments that they lack the funds to proceed with this program. It seems obvious, therefore, that if they are unable to proceed because of a shortage of funds and still they are getting some funds from Federal that the best thing to do is have the Federal to increase its present share.

COMMISSIONER FIRESTONE: If I understand you correctly, your point is, if the Federal Government were to raise its contribution in areas where it is already making a 50% contribution say to 60% or to two-thirds that more provincial governments might be prepared to implement certain programs which they have so far been hesitant to implement because of financial difficulties. Is that your point?

MR. HALL: I think so, provided there

was a great effort made towards personnel, because you cannot get the program going without personnel.

COMMISSIONER FIRESTONE: And you are in favour of the percentage as I have suggested or put in the form of a question of 60% or two-thirds?

MR. HALL: Yes, we would favour any action which would bring about a reduction of the present difficulty.

COMMISSIONER FIRESTONE: Thank you very much.

/BL/dpw

COMMISSIONER BALTZAN: Gentlemen, I have this question for information. On page 1, paragraph 2, you say:

> "All chidren, irrespective of whether or not they suffer from mental or physical handicaps, should have every access to the best medical diagnosis and treatment," etc., etc.

My question is this, and I hope you may be able to answer it for me. In your experience so far in all that is available, what has been the degree of success in the salvage process and restoration to self-sufficiency?

DR. STANLEY: If I may be permitted to answer that with an anecdote. I remember as a new student visiting a mental hospital where retarded children were kept on a custodial basis, and I have seen Mongolian children who lacked the kind of progressive and clinical management and these children in this institution simply vegetated, their existence was vegetative and they quickly died.

Later I was to see the very same category of Mongolian children in another institution where they enjoyed proper clinical and ancillary services and these children were alert and industrious relating to other people, and the experience of watching these children and the experience of the family was very much different, was an entirely different matter.

Now, the change is not always so dramatic, but I think there is a very great difference between the

experience of a child who is properly managed and the child who is not. I think it parallels what we have seen with children in other areas, that with proper methods people can make greater use of the resources.

COMMISSIONER BALTZAN: In other words, you do see palpable results?

DR. STANLEY: Yes.

COMMISSIONER BALTZAN: On page 3, you emphasize the element of public education. You mean there the public should know the benefits which may be derived through education?

DR. FRANK: That is right.

COMMISSIONER BALTZAN: And also do you encounter any difficulty in people not knowing that there are in existence certain opportunities available to them?

DR. FRANK: Sometimes that occurs, yes.

COMMISSIONER BALTZAN: We have heard that in other provinces.

DR. FRANK: Yes, sometimes that occurs. And another point in public education is the fact that the parents will not recognize the disability, so the suffering is on the person, and this is one of the problems as well, and our great concern and the problem is that from a national point of view there is a stigma being borne in other parts of the country in relation to being mentally retarded.

So irrespective of the contribution financially, whether it is at the federal level or provincial level, this, I think, is not a matter for hard and

fast decisions, splitting a line somewhere; but I think in relation to the needs of the child who is handicapped so it does not become a curse to a family having a child born in one part of the country rather than somewhere else. This is what is presently occurring, and we find areas where the care is at a very high level and areas where there is no programming at all, and other areas in between.

So as I pointed out on page 1, this is the backbone of the World Health Organization brief, that this cannot be true in this country, but they have such access only in the area in which they are brought up. It is rather a sad story.

COMMISSIONER BALTZAN: Thank you. One last question in relation to the total problem of retardation and the physically handicapped. From your broad experience do you notice that the incidence is related to either the higher or lower income groups?

DR. FRANK: The lower - no, not income group. I don't think there is any relationship between the mentally retarded child with physical disability to the economic status of the family or even the intellectual status of the family. These are brought about by conditions of which we know very little, that is the causation of it. But it is not related to the financial or intellectual status of the family.

COMMISSIONER VAN WART: I notice on page 5 you speak of the co-operation of the government in establishing registries, and so on. If a plan or plans should come in involving personal health services and

[illegible] handicaps, splitting a disc somewhere, but I think in relation to the needs of the child and its family, [illegible] so it does not become a curse to a family having a child [illegible] else. This is what is currently occurring, and there are areas where the care is at a very high level and areas where there is nothing at all, and other areas in between.

So as I pointed out in [illegible], this is the backbone of the world health organization, that this cannot be [illegible] in this country, once they have given a [illegible] in the area in which they are brought up, [illegible] service [illegible].

PRESIDING [illegible]: Thank you. One last question in relation to the total problem of retardation and the [illegible] handicapped. From your own experience do you notice that the incidence is related to either the higher or lower income groups?

[illegible]: The lower - no, not income group. I don't think there is any relationship between the mentally retarded child with physical disability to the economic status of the family or even the intellectual status of the family. These are brought about by conditions of which we know very little, that is the nature - [illegible] it is not related to the financial or intellectual status of the family.

[illegible]: I notice on page 5 you speak of the [illegible] of the government in [illegible] 5 year plans [illegible] health services and

preventive services, do you feel there is still a place for your voluntary organization to exist?

DR. FRANK: Yes, I would think so. If one can philosophize, one would hate to see services, voluntary and under the jurisdiction of a governmental agency, go. I think there are many voluntary agencies which can be complementing and be of tremendous value.

DR. STANLEY: If I might add to that. It occurs to me that some of the needs of the retarded children, for that matter, some of the needs of children with some other forms of retardation illness, can only be met by a certain kind of people, a certain kind of decent experience with other people which is necessary for the well-being of some of these handicapped children as well as blood is to a patient.

This kind of thing can only be given by certain people, and there is certainly a role for the voluntary interest, whether through voluntary services attached to various institutes or not. I think there is a very big place for the voluntary groups to give this attention and interest to handicapped people.

MR. HALL: May I say one word on that, please? I would like to point out that there is not too much difference between the normal child and mentally retarded child except that he is not able to function in the community, and therefore most of the voluntary services which the normal child gets can still be and should be handled by voluntary agencies. This is one area of the program.

Another very important function our

Association has is that they do help parents who have retarded children. So here we have a voluntary agency working in conjunction with, we hope, agencies which are going to be established if this brief is recommended. This is another area. I think it is a good concept, that the normal child and the mentally retarded child are not different except that he cannot function at quite the same level.

COMMISSIONER STRACHAN: Dr. Stanley, you made reference to dental treatment for the retarded as being done in the hospital with an anaesthetic. Do I take it you mean a general anaesthetic?

DR. STANLEY: Yes. I was referring to the fact that management of these children is so much a trial for the parents, and sometimes the practitioner, too; there is a reluctance to take the treatment, it tends to be put off. A lot of these children do seem to require general anaesthesia, yes.

COMMISSIONER STRACHAN: Then is this hospital accommodation readily available across Canada?

DR. FRANK: That is difficult to say, I would think. I gather by this you mean whether the availability for the admission of such a child to the general hospital is readily available?

COMMISSIONER STRACHAN: Or whether there are dental clinics in the hospital to do this.

DR. FRANK: Dental clinics are not readily available in the hospital.

DR. STANLEY: I think possibly this is as much a question of organization and thought being given

Association Mrs is that they do help parents who are retarded children. So here we have a voluntary agency working in connection with, so here, agencies which are going to be established in this town is recommended. This is another area. I think it is a good concept.

are two different concept that we cannot function at quite the same level.

[illegible] STEWART: Certainly, you have reference to social treatment for the retarded as being done in the hospital with no investigation. Do I take it you mean a general consultation?

Mr. [illegible]: Yes. I was really trying to [illegible] that treatment of these children is so much a total job for the parents, and sometimes the practitioner, look there is a relationship to make the treatment, it tends to be successful. A lot of these children do seem to require general counselling, too.

[illegible]: Then is this incidental to [illegible] generally speaking? [illegible]

[illegible] That is difficult to say. I would think. I gather by this you mean whether the availability for a [illegible] of such a child to the parent [illegible] is merely incidental?

[illegible] general attitude in the hospital to do this.

Mr. [illegible]: Yes, [illegible] [illegible] [illegible]

Dr. [illegible]: I think [illegible] this is [illegible] such a question of [illegible] and thought being given

to this and the necessary facilities being set up. Generally a child will not be turned away from the dental department of a hospital, but setting up the necessary arrangements and having it sufficiently organized that a group of children could come in at a time, at the moment it tends to be rather a hit and miss sort of thing.

COMMISSIONER STRACHAN: On another subject, have you any idea of the number of sheltered workshops there are in Canada for the mentally retarded?

DR. FRANK: Probably about half-a-dozen.

COMMISSIONER STRACHAN: Have you any idea of the number of employees in those workshops?

MR. HALL: Probably about 150, at the most, and some of them are undergoing training.

COMMISSIONER STRACHAN: Those who have completed their training, do you find across the Dominion that industry, management and labour are co-operative in the employment of these individuals?

MR. HALL: It is a relatively new project on the part of our organization and some community agencies. It has probably only been in existence for four or five years. However, I understand that a small percentage of people have graduated from the sheltered workshop into an employment situation. But it is wrong to expect that all people who graduate, let's say, who are trained in the sheltered workshop, are going to be able to get employment in industry.

Now, there are many reasons, about which my good friends the doctors here can tell you, and to find

[illegible]

[illegible]

to this are the necessary [illegible] [illegible] [illegible] set,
generally a child will [illegible] [illegible] may [illegible] the
dental department of a hospital or [illegible] [illegible] up the
necessary arrangements and [illegible] [illegible] [illegible] [illegible]
organization that a group of [illegible] could come [illegible] [illegible] a
time, at the [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] and [illegible]
some of them.

[illegible]

[illegible], have you an idea of the number of [illegible] [illegible]
workshops there are in Canada for the mentally retarded?

Dr. [illegible]: Probably about half-a-dozen.

[illegible]: [illegible] you an
idea of the number of employees in those workshops?

Dr. [illegible]: Probably [illegible], at the
most, and some of them are [illegible] [illegible].

[illegible]

[illegible] [illegible] [illegible] do you find across the [illegible] on
that [illegible], [illegible] and labour are [illegible] [illegible] in
the employment of these individuals?

Dr. [illegible]: It is a relatively new project
on the part of our organization and some [illegible] [illegible]
agencies. It has probably only been in existence for
four or five years. However, I understand that a small
percentage of people have graduated from the sheltered
workshop into an employment situation. But it is wrong
to assume that all people [illegible] graduate, let's say, who
are training in the sheltered workshop, are going to be
able to get employment in industry.

Now, [illegible] the [illegible] [illegible], [illegible] [illegible]
[illegible] [illegible] the [illegible] [illegible] [illegible] [illegible] you, and to find

a particular employment, in some instances, to find a particular employment situation where a person is going to function, if he is going to be teased and made a fool of by the rest of his employees, he may have to be retrained to fight this sort of thing. On the question of whether or not employees are willing to accept them entirely, I don't know personally of any rejections. We haven't had too many situations where they have applied for employment.

FF/ss

In other places it has been successful in some areas and not successful in others, depending largely on the type of employment that has been made available or the attitude of the employer. Once again, we get down to the problem of public education. If we give these people half a chance they will do a job for you. If we don't give them the chance they won't.

COMMISSIONER STRACHAN: One last question, Mr. Chairman, on Page 5, Paragraph 9, the agencies could use the resources provided under the new Physical Fitness Act. Would the terms of reference of the Act permit such?

DR. FRANK: It might permit for the training of persons to supervise and develop and organize recreational programs for retarded.

COMMISSIONER STRACHAN: Nothing definite.

DR. FRANK: There isn't any definite statement as to this group, no.

COMMISSIONER VAN WART: The retarded child who obtains employment, do they have difficulty in retaining their jobs?

MR. HALL: Employment in industry?

COMMISSIONER VAN WART: Yes.

DR. FRANK: If I might just add to this, it probably isn't so much the fact that they lose their jobs as much as they possibly require closer social supervision in a general way. By this I mean the fact that the working person requires something else beside work to be organized for him. For example, his recreational and social life. This is, I think, something which the retarded person requires assistance in more than his normal co-worker

[illegible] ,[illegible] it has been [illegible]
ral in some areas and [illegible] in others, speaking
largely on the type [illegible] that has been made

[illegible] these people half a [illegible] will do a job for
you. It is not [illegible] give them the [illegible] they want

question, Mr. Dalmas, on page 5 [illegible], the
agencies could use the resources provided under the new
Juvenal Futures Act. Would the terms of reference of the
Act permit such.

[illegible] MARKS: It might permit for the
training of persons to supervise [illegible] and corrective
institutional programs for juveniles.

[illegible] STRAUSS: [illegible] defining
[illegible] there isn't any definite
statement as to this [illegible], no.

[illegible] VAN WAGT: The increased
child who obtains employment, do they have difficulty in
maintaining their [illegible]

[illegible] VAN WAGT: Yes.

[illegible] MARKS: I'd [illegible] just add to this,
it probably isn't so much the fact that they lose their
jobs as much as they [illegible] require closer social super-
vision in a general way. By this I mean the fact that [illegible]
nothing [illegible] [illegible] seeing [illegible] to be
[illegible] for [illegible] example, the [illegible]
social life. [illegible] I think, seeing [illegible]
[illegible] reason [illegible] is more than a
[illegible]

MR. HALL: I think there is a great need for improvement of capabilities and training of people that are training the retarded to work. This is another part of the problem. We have pointed out in our brief that we need additional money to assist us in this further development to get more people interested in the work. As we get more we will be able to raise the standards and the possibility of having an unfavourable reaction from the employer would be reduced. I think the point is that this whole area of work is quite new in Canada for the retarded.

DR. STANLEY: I might mention in the States there is evidence that the success of the retarded in a job is related to the vocational preparation he has had. Where he is better supervised during the early stages of the job when he is least likely to break down. There is already evidence where these things have been adequately taken care of that it worked very well. I think we referred in the brief to one group who was prepared at a school in the States, 100 of the lower echelon of the eligible group and were sent into services where they equited themselves well and had for four or five years, whatever it was. If they were carefully prepared, carefully supervised they had held their job. On the other hand, there is a high rate of break-down where they didn't have this management.

COMMISSIONER VAN WART: Is there a tendency of the so-called well workmen to make fun of them or anything like that?

DR. FRANK: There may be some element

MR. [illegible]. I think there is a great

[illegible] of appreciation [illegible]

people that are financing the recorded to work. This is

another part of the problem. We have pointed out in our

brief that we need additional money to assist us in this

further development to get more people interested in the

work. As we get more we will be able to raise the

standards and the possibility of having an unadvisable

reduction from the employer could be reduced. I think the

point is that this whole area of work is going now in

(Remarks off the recorded).

P. DRUCKER. I might mention in the

[illegible] there is evidence that the success or the recorded

in a job is related to the vocational guidance he has

had. Where we have [illegible] studying the ex-

[illegible] of the job [illegible] be is [illegible] [illegible]

There is already evidence [illegible] those things have been

[illegible] [illegible] of that is [illegible] very well. I

think we referred in the brief to one group who was pre-

[illegible] as a [illegible] in the [illegible], but of the [illegible] education

[illegible] [illegible] group [illegible] [illegible] [illegible] [illegible] where

they [illegible] [illegible] well and [illegible] [illegible] [illegible]

[illegible], whether it was [illegible] they were [illegible] [illegible]

[illegible] [illegible] [illegible] they [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible], there is a high [illegible] of breakdown where they

[illegible]

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

or anything like [illegible]

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

of that. That is one of the problems I referred to when I said they require social assistance and supervision. There is some tendency of this.

MR. HALL: On this general subject I think it is fair to point out that the present workshops are quite successful in getting contracts in industry. Of course, they work in a different atmosphere or a different environment.

THE CHAIRMAN: Thank you very much, Mr. Hall, Dr. Stanley, Dr. Frank. We are very grateful to you for your presentation and for your interest in this very important topic.

MR.HALL: I would like to thank the Commission on behalf of the Association for having received us and giving us the opportunity of making you better acquainted with the problems of mental retardation.

THE SECRETARY: I would like to call the Ontario Association for Retarded Children. The brief will be called Exhibit 240.

[illegible]

SUBMISSION OF THE ONTARIO ASSOCIATION FOR RETARDED CHILDREN

---EXHIBIT 240: Brief of the Ontario Association for Retarded Children.

APPEARANCES:

MR. R. JAQUES
MR. R.G. ANGLIN
MR. W.R. KIRK

MR. JAQUES: Mr. Chairman, members of the Commission, I would like to introduce myself as voluntary President of the Provincial Association; Mr. R.G. Anglin, our Senior Vice-President and voluntary worker in our Association and our staff representative, Mr. W.R. Kirk, who is our Executive Director of our Association.

I would like to thank you, sir, for the opportunity of presenting our brief to you and especially for your courtesy in receiving us early in the week so we might carry on with our Provincial annual conference which takes place in North Bay later this week. We thank you.

Perhaps, with your indulgence in order to place our brief and our Association in its proper perspective with regard to the National Brief which you have just been discussing, the National Association, perhaps I might be permitted to read the introduction which describes our Association and the recommendations which follow very much in line with the National Brief.

The Ontario Association for Retarded

Children is a voluntary provincial Association incorporated without share capital in 1953. It is comprised of local member units usually referred to as local associations for retarded children. The stated scope of the organization in its broadest terms is the promotion of conditions favourable to the development and well-being of retarded persons of all ages wherever they are and whatever their degree of disability.

From a handful of parents in nine charter groups holding informal classes for their trainable retarded children, OARC has grown through nine years of endeavour into a well established organization comprising 78, I might say there will be probably be 80 within the next couple of weeks, local associations and 7,000 members. There are 74 schools devoted to the training needs of 2,300 children with a teaching staff of 300. Several associations conduct adult programs, a large majority have recreations programs developed in cooperation with other community agencies. Home Care, Research, Institutions, Public Education, are other foci of attention in an ever-maturing approach to serving the retarded at both the provincial and local levels.

On behalf of all provincial associations for retarded children, the Canadian Association for Retarded Children has submitted a brief of broad relevance to the problem of the retarded as viewed nationally. The Ontario Association for Retarded Children heartily supports the entire content of this CARC brief.

It is OARC's intention in presenting this supplemental brief to acquaint the distinguished

Chairman and Members of the Commission with current developments in Ontario, to chart progress achieved in cooperation with public and private agencies and finally to indicate unresolved needs in this most crippling of handicapping conditions. Thus we shall address our supplemental remarks only to the organization and program aspects of the CARC Brief.

These can be summarized by the conclusions and recommendations contained in our brief which are as follows:

1. The Ontario Association for Retarded Children and its affiliated local units have been conducting community programs for the retarded for almost a decade. The growth pattern indicates the need that existed and yet the surface has scarcely been scratched. Urgent problems demand forthright action at all levels of government and by communities if this social problem is to be coped with before it becomes an even greater human blight.

2. A major need at both federal and provincial government levels is a coordinating function in respect to the problem of mental retardation. A directorate in the five main government departments concerned would be ideal. The minimum would be an interdepartmental committee appropriately staffed.

3. Well-mounted and well-supported basic research projects in the medical and social

sciences conducted in universities, clinics, hospital and school settings would provide many pieces to the etiological puzzle of retardation. Break-throughs could be hoped for. Prevention of the problem tomorrow demands investment today. OARC's contribution is recorded.

4. In working toward a battery of services to meet the physical and mental health needs of the retardate and his family, the following are pin-pointed recommendations.

a. At least two other clinics similar in size and stature to the Childrens' Psychiatric Research Centre (London) located in Toronto and Kingston.

(b) Training in mental retardation for public health nurses and greatly enlarged assistance to parents by the public health nurses and other community agencies such as mental health clinics.

(c) Grant assistance at either or both municipal and provincial levels of government to assist local associations in providing pre-school or nursery school programs.

(d) Encouragement to young teachers to prepare themselves for teaching educable and trainable retarded children through various devices using the most effective instruction techniques yet to be learned through research.

(e) There is a critical need for vocational counselling and training for the educable over sixteen; and for the over eighteen trainable, sheltered employment on a long term terminal basis.

(f) Expanded recreations and leisure-time programs for both the trainable and educable child and young adult.

(g) In addition to present hospital school residential treatment centres, there is desperate need for a growing system of small residences located strategically throughout the province to service large pockets of population. Such centres shcuild be adequately staffed at all levels with fully trained persons whose salaries are commensurate with their work responsibility, training and experience. The emphasis of the program should be toward training and habilitation.

THE CHAIRMAN: Thank you, Mr. Jaques. Now, Mr. Jaques, Mr. Anglin and Mr, Kirk, you have heard of the discussion with the Canadian Association. Now, just dealing generally have you any comments to make on the questions and answers that were given at that time specifically?

MR. JAQUES: Yes, there are one or two points.

THE CHAIRMAN: If you would.

MR. JAQUES: Repeatedly throughout the discussion of the CARC was the question of public education,

and the necessity for the existence of voluntary agencies even if total government service were available. I think these two things are pretty well directly related to one another. One aspect of public education that wasn't mentioned, but which I think is very important, was the fact that we all realize that the implementation of these programs will arise from Government spending, either Provincial or Federal. I think one great chore which faces us as an Association is to create a sympathetic reaction within the public mind which is necessary before any Government can make such expenditures, and to realize the need and be sympathetic to such increase in Government spending. With regard to the provision of much wider scope of services by Government agencies, I think specifically of hospital schools -- it is almost inconceivable to think that under the most ideal situation that a hospital school can ever provide the staff to create a second home for the children. There would be many things for children within residential facilities that our organizations and auxiliary services to the hospitals could well provide a great deal of help. In this regard we are very happy to say that in Ontario this is becoming much more in evidence. We are now being welcomed in the hospital schools and being given an opportunity to assist with their programs within the hospital school. Perhaps Mr. Kirk would comment with regard to the extent of dental care within the hospitals as it relates to Ontario, with your permission.

THE CHAIRMAN: Mr. Kirk.

MR. KIRK: Mr. Chairman, and Commissioners,

at the present time our Ontario hospital services plan covers very nicely the hospitalization for retarded children requiring the special type of treatment described by Mr. Hall. I understand that the dental and medical profession are working toward a common goal here. I think dentists under this situation feel much happier if a licensed anaethetist is on hand so that every precaution can be taken care of and, hopefully, our hospital administrators on these occasions will make sure that a bed or two is on call all the time. This has got to be a definite problem for the parents of these children and this is possibly why in our travels in local association schools we see so many children whose teeth are in very, very grim condition. I wonder, Mr. Chairman, if I may while I am on the stand here speak to the shelter work situation in Ontario at the present time. We have fifteen workshop organizations for trainable young adults. In some cases those higher up in the educable group but who would be difficult to place in industry are included in the program. In the metropolitan schools some of them have been trained sufficiently to go out and hold a job. The success that these people have had is very good in that only two of them have proved unreliable. As to the trainable group this is a real challenge to see what these young people can do.

I can think of a young woman in the London workshop. I think Dr. Strachan may know about this young lady. Ten, twenty professional people, every one of us would have written her off yet she has stamped the numbers on two million envelopes for the assembling

of the dial phone, for the telephones of Northern Electric, the numbers to be inserted on the telephone.

Similarly, our workshops are gaining increasing acceptance. Subcontracts are coming in and we are proving more and more that these young people can lead useful lives in the community. Sanger's study in New York, which is one of our old reliables indicate that about 70% of the parents of young adult retardees want their children home, so it evolves upon us to create a work and training situation so they can fulfil their place and do a creative job.

At the present time close to 200 young people in Ontario who have left our schools, carried on to adult program and our prediction would be within the next year or two we will probably have 25 to 30 workshops with about 400 doing subcontracts for industry.

Just to indicate how our local associations have taken the challenge: They forcefully announce this in their notices that this is an industry doing nuisance jobs for industry and they keep very busy sir.

DR. JAQUES: That is all I wish to comment on specifically sir.

THE CHAIRMAN: Mr. Anglin, do you wish to add anything?

MR. ANGLIN: Yes sir, thank you. I think Mr. Jaques just mentioned in connection with voluntary service the question was raised earlier, I believe, about the co-operation among volunteer services.

We have a very informal but very close and excellent co-operation with the Canadian Mental Health Association. It operates hospital auxiliaries

for many of the mental hospitals and two of its auxiliaries are now working with the Ontario Hospital Schools for Retarded Children. They do a job that is difficult for parents who are scattered to do because they are right there in the community, and make a great contribution in this regard.

We have no meetings with these people, but we meet with them and are regularly in contact with them at one of the other hospital schools and one of the newest ones. Our own groups have worked on an auxiliary committee with these other volunteer groups to bring visitors into the hospital, and of course, our own groups do provide a lot of volunteer help operating on a visiting nature to the hospital schools so there is quite a happy informal co-ordination in these efforts and I think this volunteer sort of effort must always go on.

There is no one in this work that has any feeling that we must leave this all to someone else because, in fact, we have learned nothing happened to any great extent in this area until the public interest was aroused by Associations like our own.

The point to which I would like to draw attention sir was the point raised by Dr. Frank that there is an unfair difference in the services provided for retarded children in various parts of the country. It's always unfortunate when a retarded child is born, but I think it might be safe to say, without raising too much of an argument, that the most fortunate area for a retarded child to be born in, at

the present time, or the recent past, is in the vicinity of London, Ontario and that is because of the psychiatric research institute recently established by the Ontario Department of Public Health at London, which you will find described in some detail in both of these briefs.

I draw this to your particular attention because your chief concern is with the medical services. We found the contribution in two years by this institute is absolutely incredible. It's helping every phase of our work, not merely the medical. The job they are doing in parent counselling, in helping to co-ordinate community facilities, just about every part of the work that you will find mentioned in either of these briefs. They, in their area, are helping it to generate.

It has been said sir, that we should not segregate a retarded child and say you, go into this door to this clinic and another type of person come in another door. I think most of us might agree with this except my own experience has shown that until there are special facilities which master the problem so little understood up until recently of the retarded child, the special attention they require will not be forthcoming.

Since the opening and the two-year experience of this special clinic for the retardees, the Ontario Department of Health is now attempting to refer all admissions to its hospital schools through one of the, I think it is nineteen regional mental health clinics which are operated by the Department.

Now, these clinics through force of pressure and case load have never before taken as marked an interest in the mental retardee as they have done since this special clinic was established and we feel that the establishment of further such clinics -- we ask or suggest here there should be two others, and I think the figure of 15 or 18 is mentioned for all of Canada by the C.A.R.C. brief. This is all fundamentally important to generating a great many of the other services and it's directly a medical function in the first instance. Thank you.

COMMISSIONER STRACHAN: Mr. Kirk, I had the privilege of visiting the school and the sheltered workshop one afternoon back in January and I certainly recalled the girl to whom you referred and following your remarks, Mr. Anglin, I am very proud that I come from London.

There is one question I would like to ask: Who stands the expense of building these schools for the retarded children?

MR. JAQUES: At the present time the Provincial Department of Education is paying the capital expense grant of still 30%. The rest of the money is raised by our own local Association through fund-raising drives and all the various and devious means that they have for raising funds and some enjoy additional grant support, to some degree, from municipal boards and service clubs. Their own fund-raising efforts, many other volunteer organizations and women's groups, and so on, trying to get them all into the field of fund-raising,

but basically it is 30% from the Provincial Department of Education. In some instances some support from municipal councils and the rest of it they raise themselves with the help of volunteer organizations.

COMMISSIONER STRACHAN: Who bears the current expenses of the school?

MR. JAQUES: The Provincial Department of Education is paying a grant presently of $300.00 per year for half-attendance and $550.00 per year based on full day attendance. This grant was increased just recently to these figures so that we haven't had a chance to accumulate statistics which will show what percentage these costs cover, but I think an educated guess it would be somewhere between 60 and 70% of the operating cost of our schools. The rest of the money is found through, in some instances, grants, again from the local municipality and the rest the local Associations go out and raise themselves.

COMMISSIONER STRACHAN: The teachers of these schools have special training?

MR. KIRK: Mr. Chairman, about 60% of our 300 teachers hold teaching certificates. Some are first class permanent. Some are interim. The other 40% attend -- all teachers are encouraged to attend a summer school given by the Department of Education at Northern Vocational School and they take common lectures with teachers who are preparing themselves for opportunity class teaching, and break off into their own part of the program in the afternoon.

Practically all of our teachers have

had this course. Some of them have taken it two or three times, they have found it so helpful and the Department now has under consideration an advanced course for those who have had the first course.

This is the extent of the training. In the odd instance you will find a teacher who has had some special training, special education in the United States, but they are rather rare.

COMMISSIONER STRACHAN: Is the turn-over of teachers very large?

MR. KIRK: No sir, it isn't.

COMMISSIONER STRACHAN: You seem to be dedicated people.

MR. KIRK: Our local Association do not seem to have any severe trouble hiring teachers and there is very little turn-over.

COMMISSIONER FIRESTONE: Mr. Jaques, on page 1 of your brief you recommend strongly that an officer having special concern for the problem of mental retardation be named in each of the departments of health, education, welfare, reform and labour at both provincial and federal levels. And that these should form an inter-departmental committee headed by a chairman whom you would suggest be called the Director for Mental Retardation. You also say that some similar arrangement should be worked out at the Federal level. Would you tell us specifically what you would want this Federal officer to do bearing in mind primarily the responsibility in this field is a provincial responsibility?

had this course. Some of them have taken it two or three times, they have found it so helpful. The department has gone under consideration in advanced courses for those who have had the first course.

This is the extent of the training. In the odd instance you will find a teacher who has had some special training, special education in the [illegible] but they are rather rare.

[illegible] I think that's the [illegible] or [illegible] very large.

[illegible] No [illegible] it [illegible]

[illegible] You seem to [illegible]

[illegible] to have [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]

[illegible]

MR. ANGLIN: I think the idea there sir is we find a lack of co-ordination, at present. We get confused ourselves. We have our own Committee and our own Association that have different responsibilities and we find the institute committee going to see the Department of Health and the Education Department going to see the Department of Education.

We, of course, in the Ontario Association have had very little experience, in fact, none in approaching Ottawa but we feel simply that this co-ordination must go on up the line. As, indeed, in our brief the attempt was made -- I should say first that we made a suggestion for a similar purpose but of a different nature in a brief to the Ontario Government following which an inter-departmental committee was set up, which as noted here, functioned for a short while but lacking staff and for other perfectly good reasons from their standpoint did not continue. We here see the necessity, in practical terms, of such co-ordination at the Provincial level. We feel very certain that it is also necessary at the Federal level when so many of these areas, welfare grants coming down one channel, health grants down another, that at the Ottawa level one will be knocking at different doors who won't know too well what is going on next door perhaps.

COMMISSIONER FIRESTONE: Is this recommendation based on an assumption or on the knowledge of the facts?

MR. ANGLIN: It is based on experience.

COMMISSIONER FIRESTONE: At which level?

MR. ANGLIN: It is based on an experience chiefly at the Provincial level that there is a lack of co-ordination.

COMMISSIONER FIRESTONE: You therefore assume that since there is a lack of co-ordination at that level then there is a lack of co-ordination at the Federal level. You would like to see this system which you have recommended adopted. Is that your point of view?

MR. ANGLIN: I think that is pretty well it.

COMMISSIONER FIRESTONE: Thank you very much.

THE CHAIRMAN: Doctor Baltzan?

COMMISSIONER BALTZAN: I have been very happily spared. All the questions I had in mind have already been answered.

THE CHAIRMAN: Mr. Jaques and Mr. Anglin, Mr. Kirk, we are grateful to you for coming forward with your brief and with your comments and for the discussion that we have had. We want to thank you.

Pmc.1/dpw

DR. JOBIN: Mr. Chairman, the next submission will be made by the Canadian Conference on Children. This brief will be known as Exhibit 241.

--- EXHIBIT NO. 241: Submission of the Canadian Conference on Children.

SUBMISSION OF THE CANADIAN CONFERENCE ON CHILDREN

Appearances: Dr. R. Gerstein
Dr. A. Ross
Mr. B.W. Heise

DR. GERSTEIN: May it please you, Mr. Chairman and members of the Commission, I will introduce the gentlemen with me. To my right is Dr. Alan Ross, Physician-in-Charge of the Montreal Children's Hospital. To my left is Mr. B.W. Heise, Executive Director of the Canadian Conference on Children. I am Dr. Gerstein, Chairman of the Board of the Canadian Conference on Children.

Because my brief is so brief I would read it in its entirety.

1. The Canadian Conference on Children is a national organization, incorporated in 1958 under Dominion Charter. The membership is primarily made up of representatives of professions and of co-operating national voluntary organizations, interested in the health, education and social well-being of children. It came into being in 1957, following a year of preliminary study.

2. The organization, through studies of specific questions conducted across Canada and inter-professional consideration thereof in committees and in

national forums, has as its purposes:

1. To establish greater efficiency in the use of existing resources available to Canadian children, avoid duplication, better co-ordinate services, and determine where there are gaps in children's services.

2. To create uniformity in the opportunities offered to children in all parts of Canada, including rural, suburban, as well as urban areas.

3. To inquire into existing fields of research related to children and to identify new fields of research.

4. To emphasize the importance of preventing unnecessary abnormalities in the physical, emotional and social development of children.

5. To provide a medium for better understanding among those engaged in children's work.

3. It consists of a national organization, supported by ten provincial committees and forty-three national voluntary organizations. It differs from local and national specialized groups, for example in the field of medicine, education and social welfare, which are concerned primarily with professional competence in their own fields, in that it draws upon individuals from the several professions concerned with the well-being of children. In addition, it includes among its membership

representatives of business, labour and parents. It, therefore, is not a new professional group but an organization that embraces representatives from a diversity of professional groups.

4. The purpose of this submission is to record with the Royal Commission on Health Services the existence of the Canadian Conference on Children, some of its past accomplishments and its plans for the immediate future.

5. Early in its history, it was decided that the Canadian Conference on Children would organize and conduct a series of studies on matters relating to the welfare of children. Eighteen studies were undertaken. While in a number of these there were health overtones, several dealt with health problems specifically. These were:

(a) Evaluation of pre-natal programmes, well-baby clinics, pre-school clinics, school health services, mental health programmes and special hospital facilities for children.

(b) Chronic disabilities in children.

(c) Infant mortality statistics.

(d) Health education.

(e) Accidents and accident prevention.

6. The results of all the studies and additional programme material were considered by over three hundred especially selected persons who assembled at Ste. Adele and Ste. Marguerite, Quebec, in October, 1960, for the first national bilingual conference or forum.

7. The proceedings of this meeting, under the title "New Horizons for Canada's Children", have been distributed as follows: 409 copies to persons who participated as attendants or in the organization of the conference. In addition, 300 copies have been sold in Canada, 43 copies in the United States and 50 copies in Great Britain and Europe. (A copy is filed with the library of the Royal Commission on Health Services).

8. Many requests for copies of several of the studies have been received from individuals, organizations and libraries across Canada. All have been sent the copies they requested. Before, during and after its meeting the conference enjoyed a most encouraging press and radio coverage. The participants were so impressed with the value of the conference that they decided there should be another held in 1965, with a similar procedure for documentation preceding it.

9. In addition to the distribution of the printed documents, many members have spoken to groups within their various communities in a majority of the provinces about some aspect of the conference in which these groups were specially interested. Certain of the co-operating organizations have included in their study programmes some conference subject in which they were specifically concerned.

10. The Ontario committee is holding a provincial workshop as a follow-up to the conference in May of this year.

11. The Department of Paediatrics and Psychiatry at the University of Manitoba, along with the

Winnipeg School Board, held a two-day Institute on "Early Childhood" in February, 1962, which was co-sidered a local extension of the Canadian Conference on Children.

12. In November, 1961, the Ontario Medical Association sponsored the second Ontario Conference on Handicapped Children. In at least two areas this Conference used study material prepared for the Canadian Conference on Children and enlisted as speakers the persons responsible for compiling the two studies.

Since this brief was prepared we have had an announcement that the Maritimes are now planning a conference in Nova Scotia.

13. A less tangible result of the Conference may be summed up in these words appearing in the Epilogue of the proceedings:

> "The experience of this Conference will mean many things to different people. One thing, on which all seemed to agree, was that a new spirit of dedication was born; a dedication to facilitate multi-disciplinary relationships within all professions to ensure that the Canadian child receives the best possible in understanding, care, training and treatment."

14. Thus, in Canada, a beginning has been made in coping with a problem that has long been evident on this continent; a problem which was stated most succinctly by Dr. Martha M. Eliot, then Chief of the Children's Bureau, Washington, D.C., in an address to

the National Council of Churches in Christ in America, at Cleveland in November, 1955, in the following words:

> "Too many of our public and private agencies, our health, social welfare and education programmes, our churches and youth serving organizations have worked in isolation from each other or with courtesy nods, only, between them ..... By this very separateness, I am convinced we are either wasting, or not using, tremendous social energy. We are failing to reach countless children who could use some help. By building emotional, as well as brick, walls around our individual institutions and agencies, we are limiting our capacity to help .....
>
> "To be as bold and inventive as the atomic scientists, calls for courage: the courage to face reality, to recognize the implications of what we are doing, or failing to do; the courage to invent, to experiment, and to test new ways of working together."

15. To conduct and compile the studies, which extended over a three-year period, to finance the Conference in 1960, and to prepare and distribute the proceedings, $88,868 was collected from private sources, individuals, business and labour organizations. The success of this Conference was in part responsible for the

organization subsequently receiving a $5,000 a year government grant. Future financial plans include solicitation of grants from Governments and Foundations, as well as private donations.

16. Since the 1960 Conference the organization has been set up on a more permanent basis. It is now proceeding to develop plans for the 1965 Conference. It is also, through its Research and Study Committee, planning a continuing study component. Some studies will be a continuation of ones started for 1960. Others will break new ground.

17. The organization came into being in 1957. Eighteen studies were conducted during the three years prior to the 1960 Conference. It held its first national bilingual conference or forum at Ste. Adele in October, 1960. Its programme included and continues to include a component of direct medical interest and much where there is a medical concern. A second Conference will be held in 1965.

THE CHAIRMAN: Thank you very much. This is a presentation that we have listened to very carefully. I think perhaps it has unusual significance in that it is the first presentation of 241 that has not asked for some money.

Dr. Ross, have you anything you would like to add?

DR. ROSS: No sir, except that this conference brought out, I think, more than anything else to me, how many disciplines impinge on the care of children in Canada and how much need there is for them to know each

organization subsequently receiving a 10,000 [illegible] year government grant. Future financial plans include solicitation of grants from Governments and Foundations, as well as private donations.

[illegible] Since the 1963 Conference the organization has been set up on a more permanent basis. It is now proceeding to develop plans for the 1965 Conference. It is doing so, through its Research and Study Committees, planning a continuing study component. Some studies will be a continuation of ones started for 1963, others will break new ground.

In 1963 [illegible] regional seminars were conducted during the three years prior to the [illegible]. It held its first national bilingual conference on [illegible] in October, 1964. Its programme included and continues to include a consideration of direct medical interest and [illegible] where there is a medical concern. A second conference will be held in 1966.

THE CHAIRMAN: Thank you very much. This is a presentation that we have listened to very attentively. I think [illegible] is of unusual significance in that it is the first presentation of [illegible] that has not asked for some money.

[illegible], does anyone have anything [illegible] to add?

DR. [illegible]: Yes, [illegible], except that this conference [illegible], I think, more than anything else [illegible], and [illegible] like the [illegible] in the case of [illegible] I think it should [illegible] here is that there [illegible]

other and have an opportunity to understand what each is doing. Too often there is a separate approach.

COMMISSIONER McCUTCHEON: Would you say the best way to accomplish that is through a voluntary organization such as the one you represent today?

DR. ROSS: We feel this would make a contribution.

THE CHAIRMAN: Rather than a Director of Services in some government department?

DR. ROSS: I think so.

THE CHAIRMAN: Mr. Heise?

MR. HEISE: I think I have nothing to add, sir.

THE CHAIRMAN: The nature of your submission, of course, does not lend itself to much questioning or interrogation. I think I might say this to you: that as our deliberations proceed, as our research people go forward, we may well find ourselves in a position where we may call upon you for some assistance and suggestions along this line of integration and co-operation between the various associations. I would, at this time, ask for your support in that regard and we will look forward to having your help because we may well need it. Questions will arise much later than today in the course of our dealing with our work which you may very well be able to give us a lot of help on. We will look forward to asking you for that help.

COMMISSIONER FIRESTONE: Dr. Gerstein, would your organization support health examinations of schoolchildren?

DR. ROSS: I would think, Mr. Chairman, that our organization would support it. There would certainly be members attending our conference who would support this very strongly. However, as an organization I do not think we are really in any position to support it unless we had made a special study of it in a conference or a pre-conference study program.

COMMISSIONER FIRESTONE: Do I understand when you said at the beginning that this seemed to be a desirable sort of objective, you were expressing more of a personal opinion rather than speaking as an organization since you have had no opportunity to consult the organization as a whole? Is that your point?

DR. ROSS: That is correct.

that our organization would support it. There would certainly be members attending our conference who would support this very strongly. However, as an organization I do not think we are really in any position to support it unless we had made a special study of it in a conference or a pre-conference study program.

COMMISSIONER FIRESTONE: So I understand when you said at the beginning that this seemed to be a desirable sort of objective, you were answering more of [illegible] since you have had no opportunity to consult the organization as a whole? Is that your point?

COMMISSIONER FIRESTONE: Because I have three more questions related to this subject, and perhaps, Dr. Gerstein, if you wish me to ask these questions I would be happy to do so. If you feel this goes beyond the terms of reference you and your associates are able to deal with, please say so and I will not ask the questions.

DR. GERSTEIN: We would be happy to hear the questions.

COMMISSIONER FIRESTONE: My second question was whether your association would support the dental examination of school children?

DR. GERSTEIN: I can only say we received a brief at our conference to that effect. Actually the total conference did not say this and pass it, but it was one of the reports that was made.

COMMISSIONER FIRESTONE: Could that study be made available to us?

DR. GERSTEIN: Yes.

COMMISSIONER FIRESTONE: The Chairman has raised a question. When this proposal was made, was it an acceptable and practical proposal or was there any reason why it wasn't dealt with?

DR. GERSTEIN: No. This was our first conference and we felt it should be kept as a forum rather than bring in people to make resolutions at that time and it was too early in the experience to come to that conclusion. That was the only reason it wasn't done.

COMMISSIONER FIRESTONE: Is it possible

CHAIRMAN PERSONS: Because I have three more questions remained to this subject, and perhaps, Dr. Gerstein, if you were to ask these questions I would be happy to do so. If you feel this goes beyond the terms of reference you and your associates are able to deal with, please say so and I will not ask the questions.

Dr. GERSTEIN: We would be happy to hear the questions.

question was whether your association would support the federal association of school children?

Dr. GERSTEIN: I can only say we received a brief at our conference to that effect. Actually the total conference did not say this and pass it, but it was one of the reports that was made.

CHAIRMAN PERSONS: Could that study be made available to us.

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Dr. GERSTEIN: No, this was our first conference and we felt it should be kept as a [illegible] from being in people to make resolutions at that time and it was too early in the experience to come to that conclusion. That was the only reason it [illegible]

CHAIRMAN PERSONS: Is it possible

to have a copy, could you make it available to our secretary?

DR. GERSTEIN: Yes.

COMMISSIONER FIRESTONE: May I go back to the possible support of medical examination at school.

DR. GERSTEIN: Yes, that was also at the conference. There are very strong feelings for setting up early diagnosis.

COMMISSIONER FIRESTONE: Is there a study on this subject?

DR. GERSTEIN: Yes.

COMMISSIONER FIRESTONE: Could it be made available to the Commission?

DR. GERSTEIN: Yes, certainly.

COMMISSIONER FIRESTONE: One third question along the same lines. Did these studies that we are talking about dealing with both medical examination and dental examination, but more particularly on the medical examination area, did it go beyond, did it deal with the question of retardation and what to do about it?

DR. GERSTEIN: Yes. There is one study in that area as well.

COMMISSIONER FIRESTONE: Could we also have that third study as well?

DR. GERSTEIN: Yes.

COMMISSIONER FIRESTONE: This is what I think the Chairman had in mind when he said that we like to draw on the sort of experience you have been

could you have it available to us?

[illegible] FIRSTBROOK. May I go back to the possible support of medical examination at [illegible].

[illegible] Yes, that was also in the [illegible]. We have very strong feelings for [illegible].

[illegible] FIRSTBROOK. Is there a study on this [illegible]?

[illegible]. Yes.

[illegible] FIRSTBROOK. Could it be made available to the Commission?

[illegible]. Yes, certainly.

[illegible]: One thing [illegible] the same lines. In these studies that [illegible] dealing with your medical examination and mental examination, but more particularly on [illegible], did it be lowered, and it [illegible] the possibility of predictor [illegible] to [illegible]?

[illegible]. There is one study in [illegible].

[illegible]: [illegible], will we [illegible] that [illegible]?

[illegible]

[illegible] I'm [illegible]. This is not [illegible] we [illegible] of the [illegible] you have been

gathering, and if it could be made available to our research staff we would have the benefit of the great work you have done or your associates have done.

DR. GERSTEIN: Yes.

COMMISSIONER FIRESTONE: Have there been any proposals or studies done which would recommend that there should be free milk or free orange juice to school children and to improve the diet and nutritional standards of school children?

DR. ROSS: This was discussed at some length, but no direct recommendation from the conference.

COMMISSIONER FIRESTONE: I appreciate no recommendation has come forth in any of the areas, but you say there was a discussion on the subject. What was the gist of that discussion?

DR. ROSS: I am not sure that I could offhand give it. We did not keep detailed minutes of all the discussions that took place at the conference. They were done in study groups, and I think the only reports we have in detail come from the pre-conference studies which were made available to the people attending the conference before it actually took place.

COMMISSIONER FIRESTONE: Was there a pre-conference study on this subject?

DR. ROSS: No.

COMMISSIONER FIRESTONE: Was there a record kept of the discussions that took place on the subject under study?

DR. ROSS: I don't believe so in that case, no.

COMMISSIONER FIRESTONE: Now that you know the area of the interest of the Commission, there may be other questions on the area I have raised, and we would be pleased if these could be made available to our secretary. Thank you very much.

COMMISSIONER BALTZAN: Just one question, and it is this. If I understand you right, then my question may be proper. But I will put my question. Is your organization working towards any kind of new image of the kind of Canadian child of the future? You have no specific things here except what you want to take up in your research projects. One is to emphasize the importance of preventing unnecessary abnormality, providing a better understanding, and so on. This belongs to a separate organization of your organization?

DR. GERSTEIN: Yes.

COMMISSIONER BALTZAN: Does your organization stand for ---

DR. GERSTEIN: A combination of all. If you are asking if we have thought of having a kind of children's charter kind of thing, we haven't actually worded one which anyone would accept at this moment. We haven't worked directly on it.

COMMISSIONER BALTZAN: But you have that sort of thing?

DR. GERSTEIN: Yes.

COMMISSIONER BALTZAN: Then I think my question is proper.

COMMISSIONER GIRARD: Was your conference

more or less on the White House conference on children?

DR. GERSTEIN: This was our first conference, which involved only 300 persons, whereas the White House conference involves thousands. But it is very much the kind of same thing.

COMMISSIONER GIRARD: I had very good reports of this conference and people said it was very helpful, and I wondered if it could be developed along the lines of the White House conference?

DR. GERSTEIN: If I may point out, we don't have a children's bureau to carry it out.

THE CHAIRMAN: Thank you again, Dr. Gerstein, Dr. Ross, Mr. Heise.

We will now rise, to continue at 9:30 tomorrow morning.

---Adjournment